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# HOMO MEDICUS*

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The Author. *Charles J. Ashworth, M.D., President, The Rhode Island Medical Society, 1950-1951.*

THE DECLINING YEARS of the fourth century Before Christ, gave to the world and posterity, an ever since famous physician, Hippocrates, called the father of medicine. Known to moderns better by his oath than by any positive facts about his life, this renowned utterance steeped in centuries of tradition is still the gateway to the present temples of Aesculapian lore, for all men seeking the coveted symbol of Homo Medicus, M.D.

" I swear by Apollo the Physician and Aesculapius — and all the Gods and Goddesses that according to my ability and judgment, I will keep this oath and stipulation; — I will follow that system of regimen which — I consider for the benefit of my patients and abstain from whatever is deleterious and mischievous; — While I continue to keep this oath unviolated, may it be granted to me to enjoy life and the practice of the art, respected by all men in all times."

Among the fine gold of the oath of Hippocrates, with its insistence on gratitude to benefactors, nobility of ethical standards and scrupulous observance of professional secrecy, shine those words of obligation and high resolve, the sworn promise of Homo Medicus. In those solemn words, to the Scholar's pledge gladly to learn and gladly teach, there was added the physician's engagement to serve, by the most skillful practice of his art, the community of which he is a part.

Those words of Hippocrates betoken more than mere fidelity to the best practices of the profession of medicine; inherent in them are a recognition and an acknowledgment of the social obligation inextricably connected with the physician's calling. For medicine is no esoteric and sterile science, no accumulation of knowledge and manipulative skill whose end is the personal satisfaction and adornment of the one possessing them. Medicine cannot be practiced in a vacuum, but on the mortal bodies of humanity. "Let me be sick myself," wrote Sir Thomas Browne, "if sometimes the malady of my patient be not a disease unto me. I desire rather to cure his infirmities than my own necessities. . . . I am not only ashamed," the seventeenth-century physician continues, "but heartily sorry, that, besides death, there are diseases incurable; yet not for my own sake, or that they be beyond my art, but for the general cause and sake of humanity, whose common cause I apprehend as mine own."

Down through the ages, Hippocrates has come to be looked upon as an individual embodying all that a physician should be. In his absorption of all that was good from the culture of older civilizations, he added a broader rationalism and a keener understanding from which has evolved the Art of Medicine, embracing as it should, not only healing the sick by prevention and cure of disease, but the inseparable economic and social obligations, that recent years have seen ascend to a consideration of equal importance.

The assumption that these urgent and immediate problems associated with medical care are new, is indeed a grave error. Documented evidence dating from the Egyptian Dynasties as far back as the 4-5th Century B.C. indicates that the health of a people is the greatest single asset of any nation. Illness on the other hand is and always has been recognized as the fundamental cause of economic and social dependency.

The vision of Hippocrates rose toweringly above the limitations of his technical knowledge and the broad sympathy of the philosophic Thomas Browne stands like a beacon in the semi-darkness of a century when men, banded together in the Royal Society for Improving Natural Knowledge, groped their way toward greater certitude in diagnosis and treatment than the old humoral pathology afforded. But the mainspring of their activity, the impetus that sponsored their devotion, remained, as it has been through the centuries, the desire to

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*Presidential Address delivered before the Rhode Island Medical Society at its 140th Annual Meeting, at Providence, R. I., May 10, 1951.

widen the horizons of their knowledge that they might thereby lessen the ills that beset humanity. Granted that the prying demon of curiosity has played its part in uncovering the secrets of Nature; acknowledging that the honorable tradition of medicine was shamed by pretenders to learning and self-seeking rascals like Chaucer's Doctor of Phisik who "loved gold in especial." Nevertheless, the great tide of learning that swept the art of medical practice into its honored place today flowed from those selfless searchers after wisdom who pushed back the frontiers of ignorance and half-knowledge, and gave to mankind the benefits of their discoveries and their achievements. From Galen to Osler, to Flemming, the aim and purpose before our great predecessors and our distinguished contemporaries has been to enrich themselves that men might be served.

How personal is the need of an individual in matters that affect his health. Like democracy itself, the concern of the doctor is for the welfare of the individual, a relationship that has formed the basis of medical practice through the centuries. In this period of social expansion, our people, convinced of the necessity for adequate medical care, have extended their demands for the availability of all the benefits of modern medicine to all, as well as the other aspects of security to which we have become so closely allied, namely unemployment, sickness disability compensation, maternity benefits, hospitalization, rehabilitation and prepaid medical care. This portends the proximity of medical security in this country and all its implications. How futile, if we fail to comprehend.

One would be hard pressed to discover a comparable field of activity in which higher ideals are demanded of those who engage in medicine, and are regularly, almost uniformly, satisfied. The respect, bordering on reverence, and the nearly unquestioning trust which the medical profession and its representatives are granted, arise from something more profound than the mere recuperative aids which we furnish in a crisis. They are based on, and can be adequately requited only by, the recognition that the practice of our profession is as much a social as it is a biological science. What the community expects of the physician is what Hippocrates demanded of his disciples: strict devotion to a regimen in which the welfare of the patient, every patient, is paramount, and unsullied service to humanity on the highest plane and in the widest scope possible.

As far back, therefore, as the enunciation of the Oath, the social obligations of medicine were first defined. WHAT THEN IS THE POSITION OF THE PHYSICIAN IN MODERN SOCIETY AND WHAT DOES A COMMUNITY EXPECT OF THE MEDICAL PROFESSION?

In a simpler society of recent decades, the doctor was closer to the economic problems and social anxieties of his patients. Changes in our present rate and mode of living have altered the proximity of those earlier doctor-patient relationships. Ease of communication, dissipation of distance through rapidity of transportation, urban concentration of population, industrial expansion, a philosophy of government that has crystallized a change in social concepts largely through pressure and so-called education, plus our own professional emphasis upon specialization, have all contributed to the hiatus.

The value of a better understanding of the socio-economic factor as an integral part of medical service today is of paramount importance. Medical education has an added responsibility to qualify the student in economic proficiency as well as in clinical aptitude, at both the undergraduate and graduate levels. No less a task is ours in practice, to arouse a broader social consciousness in the individual, ever mindful that medical practice is no longer, if it ever was, a private enterprise, but a public responsibility of the highest order.

HOMO MEDICUS thus projected in the light of this background has an entirely different perspective from the doctor of only a few years ago, but as the fortunes of medicine rose and fell with the cultural tides of antiquity, so too must they embrace present mutations. Time after all, is simply a measure of change and we of this medical generation are victims of one of history's periodic evaluations of our stature.

This cannot be interpreted with any foreboding of despair, but rather as an alert to extricate ourselves from a lethargy that tradition has unconsciously imposed, and a new orientation toward what any community expects from its medical profession.

This high regard which amounts to veneration by a very large majority of our people for the honest, competent sacrificing physician, stems from an awareness of what is best in medicine. It is surely not unreasonable for the public to want the best, but the demand for the best has replaced the desire. Less thoughtful minds would urge with conscious deceit, that legislation can deliver to the American people that physical comfort and mental solace that is reserved only to HOMO MEDICUS, now, as it was in the beginning and always will be. Let it continue to be ingenerate and let us remain at liberty to deal with the peculiar problems this age has made inherent in the practice of medicine. It is the very law of the human mind in its inquiry after and the acquisition of truth, to make its advances by a process which consists of many stages and is

often circuitous. There are no shortcuts and the road does not always lie in the direction in which it ends, nor are we able to see the end upon starting. It may often seem to be diverging from a goal into which it will run without effort, if we are but patient and resolute in following it out. We are told in Ethics that we may gain a means merely by receding from both extremes, so error may be said without a paradox, to be the only way to truth.

In the words of John Henry Cardinal Newman so appropriate to our present tasks: "The errors of some minds in scientific investigation are more fruitful than the truths of others. A science seems making no progress, but to abound in failures, yet imperceptibly all the time, it is advancing, and of course, it is a gain to truth even to have learned what is not true, if nothing more."

Certainly such erudite reasoning of a century ago confirms the fact that health is the product of medical progress. How true it is that a good man is one who is constantly getting better, the perfect definition of HOMO MEDICUS. Without reservation, therefore, I would plead for the cultivation of gentleness, kindness and sympathy as well as skill and knowledge. Our mission transcends the daily response to answer the signals of medical distress. This missionary spirit must embody not only the increase in medical learning, but the dispensation of that acquired knowledge to the people we serve, that they may know how to live in health or with disease.

Medicine being in the constant state of evolution that it is, trusted procedures of yesterday become obsolete as new advances are made, and with each generation the means of helping a suffering humanity, increases with a pace so fast, that the opportunities become daily more alluring.

I cannot let this occasion pass without recourse to some admonitions from previous leaders of our society. In the presidential address of Dr. Arthur Ruggles read before the annual meeting of Providence Medical Association, January 6th, 1930, he said: "The matter I want to bring to your attention this evening is the need of forceful and constructive action — concerning matters in our City and State. We have been told in no uncertain terms by numerous qualified writers and speakers that State Medicine is rapidly approaching, and, personally, I believe this to be true, unless the medical profession itself wakes from its complacent attitude and goes into action; and that action must be sustained and well directed."

In July of that very same year, Dr. Frank T. Fulton, retiring president of the Rhode Island Medical Society spoke as follows: "I am by nature an idealist and an optimist, a most unhappy combination. Life shows the futility of the one, and that tends to break down the other, but I am still firm in the belief that there are in this society men who are young, strong, generous and courageous, who with a little self-sacrifice, could, enhance our prestige, improve our practice and make us better custodians of both public and individual health. The future of the practice of medicine is uncertain. The older members of us are not especially concerned other than because of our loyalty to and our pride in our profession. But it may mean a great deal to the younger members and they should give it serious thought."

Only fifteen years ago, Dr. Roland Hammond admonished: "The profession of medicine is the custodian of the accumulated knowledge in medicine, and should use it for the benefit of the community. This knowledge, technical in nature, and developed by experience, can be interpreted to the body of the people only by persons educated to understand it and trained to apply it. No one but the doctor of medicine can fulfill these requirements. We should not hesitate to assert our claims of superiority in the field of medicine and our responsibility as guardians of the health of the public."

The impact of this thinking of only a generation or more ago becomes apodictic in the words of Dr. John E. Donley, who said in the course of his presidential address on June 3rd, 1937: "How slow in gestation is the mother of truth, how hazardous the generation, how difficult the propagation of new and fruitful ideas." Little did my philosophic friend and predecessor know with what accuracy he characterized our present problems.

Without being redundant or prophetic, no one can fail to appreciate the analogy of leadership's problems during the past two decades of your society's progress. Upon acceding to this office one year ago, I sought to impart a message to you, inaudible as it was in the cold type of our medical journal. The preponderant thought of the message was the need of UNITY. It is difficult to evaluate tangibly, the degree of progress made throughout the past twelve months, because of the many factors that defy presentation by graph, chart or any standard of measure from which one could quickly appreciate the trend that has engulfed us, in this attempt to solidify our efforts. Time forbids a detailed enumeration of even a few of the events that will endure as markers of progress in this year now ending.

But I insist that these accomplishments are yours, not mine. Leadership is only a medium of reflection, and I would avail myself at this time, by virtue of having been your president, of the opportunity to express my gratitude to the membership at large and to your elected and my appointed committees as well as the officers of society, the Council

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# THE COMPULSORY PROPOSAL . . . ITS ADVANTAGES

*as viewed by*

CHANNING FROTHINGHAM, M.D., *of Boston, Mass.*
*Chairman of the Committee for the Nation's Health*

*Dr. Channing Frothingham was offered the opportunity to present his views in this Journal, with the understanding that a reply would be given to his reasons in favor of a compulsory national health program. The Editors of the Journal are willing that this question be presented clearly for the information of the Profession. In publishing this article by Doctor Frothingham the Rhode Island Medical Journal points out that the opinions expressed are those of the author and are not to be construed as official or reflecting in any manner the views of the Rhode Island Medical Society.*

— The Editors

TO AVOID misunderstanding I affirm that I am opposed to so-called "Socialized Medicine" as it has been developed in many countries of the world including Great Britain. I am also opposed to the type of so-called "Socialized Medicine" which the American Medical Association claims S.1679 calls for. The type of so-called "Socialized Medicine" which the American Medical Association so violently opposes has not been included in any of the important health bills introduced into the United States Congress in recent years, certainly not in S.1679, 81st Congress.

At the moment of writing no bill calling for the development of a comprehensive National Health Program has been introduced into the 82nd Congress, but undoubtedly there will be one similar to S.1679, 81st Congress. As that bill contained the philosophy in regard to the method of delivering and paying for personal health services which I approve, I will use its proposals for the subject of discussion.

This bill contained a variety of provisions other than the one to provide and pay for the delivery of personal health services. However, as this provision is the most controversial, and as my space is limited, I shall confine my discussion to it. This provision provided for the payment for personal health services through a new tax called Compulsory or National Health Insurance to be collected at the federal level in proportion to income with contributions from employers if the individual is employed. Self-employed individuals are also included. It further provided that those who were forced to contribute would be eligible for personal health services delivered as they are at present at the local level under certain general regulations to guarantee good quality care developed at the federal level.

Opponents to this philosophy admit that some program is necessary to provide a method for the majority of our citizens to pay for personal health services, and organized medicine has favored the development of voluntary non-profit insurance plans, such as Blue Cross and Blue Shield with supplementation from general tax funds where needed. Commercial insurance companies have for years offered policies to cover part of personal health services, but as the existing needs have developed in the presence of these opportunities I will assume that they have been insufficient to solve the problems. I will confine myself, therefore, to pointing out the advantages to the individual in having his personal health services provided as outlined in S.1679, 81st Congress over the present fee-for-service method supplemented by Blue Cross and Blue Shield Insurance.

Under the Compulsory Health Insurance Program all those millions who although not actually indigent but still have to accept charity medicine in part or in full, the so-called medically indigent, will have a right to personal health services. For these millions the so-called "means test", so distasteful to Americans will no longer be applied before they can receive medical care. To them will come the chance to enjoy free choice of physician, which does not exist in our charity clinics and which is considered such an important factor in American Medicine. The medically indigent will cease to exist and provision was made so that the actually indigent could be included in the program if their communities so wish. On the other hand up to the present time despite the tremendous growth of the Blue Cross and Blue Shield Plans which only offer partial coverage, the number of medically indigent in our charity clinics appears to remain constant or even increase at times.

The quality of personal health services must not be allowed to deteriorate under any new program for paying for them. Fortunately the quality of care should improve under the program for its

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# THE COMPULSORY PROPOSAL . . . ITS DISADVANTAGES

*A reply to Dr. Frothingham by*

LOWELL S. GOIN, M.D., *of Los Angeles, California.*
*President, California Physicians Service, and Past President,*
*College of Radiology and the Radiological Society of North America.*

*Dr. Lowell Goin is one of America's outstanding physicians, anl he has been equally outstanding as a spokesman on national legislation affecting health and welfare in this country. The Editors of the Journal invited Doctor Goin to reply to Dr. Frothingham's presentation. The opinions expressed by Doctor Goin are his own, and are not to be construed as official or reflecting the views of the Rhode Island Medical Society.*

—The Editors

I AM IMPRESSED by Dr. Frothingham's opening statement: "I am opposed to so-called "Socialized Medicine." The statement indicates that Dr. Frothingham is a literate person who has studied the Scholia appended to "Jurgen", in which the tumblebug accuses Jurgen of lewdness saying that he preferred to say that the lance which Jurgen carried was *not* a lance. The weakness of my thesis is that one finds it difficult to explain, on the same basis, the fact that Mr. Truman also is opposed to "socialized medicine." Of course the fact is that the words "socialized medicine" mean, to an overwhelming majority, compulsory health insurance (better called compulsory sickness tax) and regardless of protests will continue to have that meaning.

The fourth paragraph of Dr. Frothingham's communication sharply delineates the weakness of the position of the proponents of so-called national health insurance, in that he *assumes* that other methods of supplying medical care have been insufficient to solve the problem. This assumption is a stock article with those who support this section of the Marxian doctrine, but one which is never documented with facts. Apparently it suffices, in the curious dialectic employed, to assume something, and to proceed as though the assumption were a demonstrated fact.

That the medical indigent will receive "health services" under any legislation thus far proposed is simply not true. The great number of the unemployed, and the unemployable, including those who are too old to work, will receive no care whatever. Only persons who are gainfully employed (and perhaps a few self employed, although one doubts that many will commit themselves to beaurocratically controlled medical care without compulsion) are eligible to the alleged benefits to be administered by the Federal Security Agency. Obviously, the statement that "the medical indigent will cease to exist" is completely without foundation in fact.

How will the insured have "free choice of physician?" Of course the various bills proposed *say* that there shall be free choice of physician, but how shall it be accomplished? Panels will be formed. (Every proponent who has testified in behalf of national health insurance has agreed that no other method is practical.) Panels must be limited; the most popular doctor in a community will have his panel filled first, and will have to reject subsequent applicants. Almost certainly a directive of some sort will require a person to accept a physician in his own locality, instead of selecting the one he prefers but who lives outside the immediate locality. Free choice of physician in compulsory health insurance is a pleasing phrase, but it is a myth. That "the quality of medical care should improve" under Federal direction is another assumption and one completely unwarranted. One may equally well assume that the quality of medical care will deteriorate tremendously, and one would be rather better prepared to defend the second assumption.

All of the proponents of health insurance talk glibly about the preventive medicine to be furnished, but the proposed legislation is pretty vague about it. I don't know what will be proposed next, but some very interesting language was employed in a very recent version of the Murray-Wagner-Dingell bill. The bill directed the Surgeon General (of the Public Health Service) to administer the law in such a fashion as to "prevent accident, disease, and premature death." The quality of the thinking employed and the contact had with reality by the framers of the legislation is extraordinarily well exemplified by this directive. Just what will the harassed panel practitioner do when Mr. A. says he has a slight cough? Will he have Mr. A. bronchoscoped at once? If so, where shall we get the bronchoscopists, or even the bronchoscopes? If not, how will lung cancer be prevented? Shall all people with indigestion have careful radiological studies? Shall patients with headache have encephalograms? Just

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delivery set up in S.1679 as it will eliminate some of the unfortunate features of modern practice that have been brought to light by recent surveys dealing with problems involved in good quality care. Let us consider a few points which are generally admitted to be important to guarantee quality and compare existing conditions under Blue Cross—Blue Shield with the proposals in S.1679.

Encouragement of preventive medical procedures, provision for periodic medical check-ups and availability without extra cost of a family physician for early diagnosis are essential in any program which aims to provide a good quality of medical care for the individual. Yet presumably because of insufficient funds the voluntary non-profit insurance plans make very little if any provision to encourage these activities, and often actually discourage them by making an extra charge for the services. Senate 1679 encourages these activities without extra charge. Any practitioner of experience knows only too well how often with disastrous results a patient will omit preventive medical procedures or periodic check-up, or get his early diagnosis from drug clerks, friends or cultists, and even start treatment without proper diagnosis just because of the expense of fee-for-service. These temptations still persist under Blue Cross and Blue Shield but will be eliminated under the plan outlined in S.1679.

Experience has taught that it is wise for a patient to have one family physician acquainted with his environment to whom he goes for all his medical problems and by whom he is referred to other physicians for special diagnostic aids, consultations or special forms of treatment. The Compulsory Health Insurance Program insists on this procedure for medical care to be paid for from the public funds, and at the same time encourages the frequent use of special diagnostic aids and consultations, thus eliminating the money barrier between the patient and the conscientious family physician. In the voluntary non-profit plans there is no restriction on the patients shopping around among doctors or going to the specialist direct. Furthermore, because of lack of funds there is serious limitation on the amount of special diagnostic aid and consultations included in the contracts.

Some conscientious physicians feel that because a patient under the S.1679 program cannot go to a variety of family practitioners or directly to the specialist and have the bills paid from the fund, there is no free choice of physician. This is an erroneous conception, because actually a patient may change his family physician just as he can under the present system. The only restriction is that he cannot have two or more family physicians paid from the public funds at the same time. Likewise although the patient may not go to the specialist direct and have the bills paid, he can ask for consultation with any available specialist just as he can today. Furthermore, there is no restriction upon a patient going direct to any physician and paying personally for the services.

Medicine is so complex today that a physician should limit his activities to what he is qualified to do. Such decision is often difficult, but experience makes it clear that laymen with professional advice, such as hospital trustees, have been successful in limiting activities of physicians. Organized medicine, however, has never seen fit to limit the professional activities of its membership. Proper control of physicians' activities has improved the quality of medical care in many of our medical institutions. Senate 1679 calls for lay control with professional advice in formulating standards. The Blue Cross and Blue Shield plans are universally controlled by organized medicine, and in some states must be so controlled by law, and do not limit the activities of the participating physicians.

Protection of the privacy of medical records is better provided for in S.1679 than in the Blue Cross — Blue Shield plans because there is a penalty for violation in the former but not in the latter.

In summary among the advantages for the patient under the proposed National Health Insurance for millions of our people are the elimination of charity medicine and the "means test," and opportunity to have free choice of physician for the first time, the guidance of one's medical problems by his own family physician with unlimited laboratory aids and consultations, and the money barrier between patient and physician eliminated. In addition preventive medical procedures and early diagnosis by the family physician are encouraged and physicians are restricted in their activities to their qualifications by lay participation in formulating rules. All of the above are of importance in guaranteeing good quality of medical care.

In conclusion let us explore how the physicians will fare under this program. In the first place no physician will have to participate. Just as today many people do not avail themselves of the opportunity for education as offered by taxation, so there may well be many who will not avail themselves of the medical services offered under National Health Insurance. From this group the non-participating physician could draw his clientele. It should further be made clear that no physician will have to accept a patient unless he wishes to, nor will he be assigned to any particular area to practice. In other words complete freedom for physicians will continue as it exists today with the only difference that

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how will this boon of preventive medicine operate? Of course Dr. Frothingham knows quite well that much of the talk of preventive medicine is wishful thinking and that medicine has not reached the goal toward which it is struggling. But it reads well.

"The Compulsory Health Insurance Program insists" on care by the panel practitioner, "and at the same time encourages the frequent use of special diagnostic aids and consultations." When I read this statement, I wondered whether Dr. Frothingham had read S.1679. It actually provides that a specialist may be consulted *if the attending practitioner thinks it necessary, or if authorized by the regional medical administrator*. One has seldom encountered two more mutually contradictory statements.

I hope that everyone has read carefully the statement by Dr. Frothingham which says: "In the voluntary non-profit plans there is no restriction on the patients shopping around among doctors or going to the specialist direct." With this statement consider also this pronouncement: "Organized medicine, however, has seen fit to limit the professional activities of its members." Digest well these two statements: In them the Committee for the Nation's Health and the planners of the Federal Security Administration have unwittingly disclosed their hand. Here is State Socialism in the raw confronting you. Here is a man saying frankly to you that liberty and personal freedom are bad; that governmental direction is what is needed. To most of us it seems entirely right and proper that a sick person should go to the physician of his choice, specialist or general practitioner. Most of us would resist violently any attempt of organized medicine to limit our activities. It is very difficult to understand how the same voice can praise the freedom of choice of physicians to be encouraged by health insurance and, a moment later, complain that patients have too free a choice. The dialectic of Socialism, however, has never been distinguished by the logic employed.

"In summary", says Dr. Frothingham, "among the advantages" * * * * (of National Health Insurance) * * * * are the elimination of charity medicine and the 'means test,' * * * * unlimited laboratory aids and consultations." In passing one might recall that St. Paul thought very highly of charity, but it is now scorned unless it has its new name, "directed contribution." But how is charity eliminated? How do the unemployed, the aged, and the unemployable receive their "insurance" care? How do the insured have "unlimited consultations" when the proposed law says plainly that the insured may have the services of a specialist if his attending physician recommends it, or if it is ordered by the regional director? I'm sure that he is speaking truly when he says that "physicians will be restricted in their activities * * * * by lay participation in formulating rules."

Well, there you have it. A distinguished proponent of National Health Insurance has outlined the advantages of the plan for both the insured and the physician, and a most casual glance shows the alleged advantages to be entirely imaginary. He has also stated in unmistakable language what the Socialist planners have in mind for all of us; limitation of our liberties and our personal freedom. His communication is of inestimable value to every reader, since one cannot fail (after reading it) to reaffirm and to strengthen one's opposition to compulsory sickness taxation, alias health insurance, and to all other fragments of the Marxian doctrine.

**INTERIM SESSION . . .**

**R. I. MEDICAL SOCIETY**

***Wednesday, September 19, 1951***

**at DUNES CLUB**

**NARRAGANSETT, R. I.**

## DR. CHANNING FROTHINGHAM
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there will be no financial transaction between the patient and the physician. With this money barrier between the patient and the conscientious physician eliminated the pleasure of practicing medicine should be enhanced.

Healthy competition between physicians would be preserved by the freedom of choice of family physicians by the patients in the same manner that they have today. The plan encourages group practice with all the advantages of vacation, opportunities for refresher courses and the stimulation of intimate contact with fellow physicians. On the financial side the family physician, the successor to the general practitioner, should fare better because he will no longer have charity patients nor uncollectable bills. The financial sufferers would only be those specialists who have big incomes from large fees. Perhaps that would be for the better.

# CO-EXISTENT SARCOMA AND CARCINOMA OF THE UTERUS

## — *A Case Report*

GENE A. CROCE, M.D. AND ELIZABETH MEYER, M.D.

The Authors. *Gene A. Croce, M.D., Junior Surgeon, Gynecological Staff, and Elizabeth Meyer, M.D., Pathologist, Rhode Island State Hospital, Howard, R. I.*

That the co-existence of sarcoma and carcinoma of the uterus is a rare occurrence is evidenced by the fact that only about thirty cases have been reported in the English literature. Besides, in a number of these cases, the diagnosis as such has been questioned by some observers.

Ewing[1] has described this entity under the name of carcinosarcoma as arising from the endometrium, possibly as a response of the different elements to a common stimulus and suggests the following groups:

1. Carcinoma and sarcoma arise as separate tumors and can be grossly distinguished.
2. The two tumors arise separately but later one invades the other.
3. Carcinoma develops secondarily at a point where the sarcoma reaches the endometrial surface.
4. The glands included in a sarcomatous polyp become malignant.
5. The stroma of a carcinomatous polyp becomes malignant.
6. Atypism of either stroma or glands is mistakenly diagnosed as evidence of a second tumor.

There is little agreement as to the criteria for classification of the different varieties and the number of names used interchangeably, such as carcinoma sarcomatoides, carcinosarcoma and sarcoma plus carcinoma is quite confusing. We believe, as do Lisa et al.,[2] that the definition carcinosarcoma should be reserved for those cases showing carcinomatous and sarcomatous features within the same tumor.

The following case is reported as representing 2 independent tumors within the same uterus, one a typical sarcoma, the other a low grade adenocarcinoma with acanthomatous features.

The patient, a 60 year old white female, had been hospitalized since 1943 because of epileptic psychosis. In March 1950, she began to have vaginal bleeding. The menopause had occurred at the age of 40 when her "female organs" were removed. At the time of examination in the Gynecological clinic vaginal bleeding was present and a greyish necrotic mass was seen protruding from the dilated external os. The fundus was symmetrically enlarged and boggy. No adnexae were palpable. Microscopic examination of a small piece of this necrotic material showed no recognizable tissue, only necrotic material with acute inflammatory reaction. The following week a complete hysterectomy was performed. To date, the patient is well, but she is being followed for metastases.

Pathological examination of the specimen showed a uturus filled and distended by a large, soft, necrotic mass which protruded, somewhat, from the dilated cervical os. This mass arose on a broad base in the right cornu and had the size and shape of a large pear. The distal portion was completely necrotic, hemorrhagic and friable. Near the base many areas showed a fishflesh-like or gelatinous appearance and had a firmer consistency. The remainder of the cavity was lined by pinkish, irregularly thickened papillomatous endometrium which appeared grossly well demarcated. The wall of the uterus averaged only 0.8 cm. in thickness. A small intramural nodule, measuring 1 cm. in diameter was present in the fundus. On section, this nodule presented the whorled appearance of interlacing fibrous bundles typical of fibromyoma. The adnexae were absent.

Microscopic examination of sections from the tumor mass show a markedly anaplastic growth, mostly composed of spindle cells but showing great variety of size and shape of cells and nuclei. Giant cells with one or more nuclei are present, most abundant around the areas of necrosis or myxomatous degeneration. Mitotic figures numerous. Some areas have a solid, sheet-like appearance suggestive of decidual cells. These cells are pale, large polygonal and show much variety in size, shape and staining properties of their nuclei (see figure 1.) An interesting section is the one taken from the base of the tumor, including the adjacent mucosa and underlying myometrium, which shows

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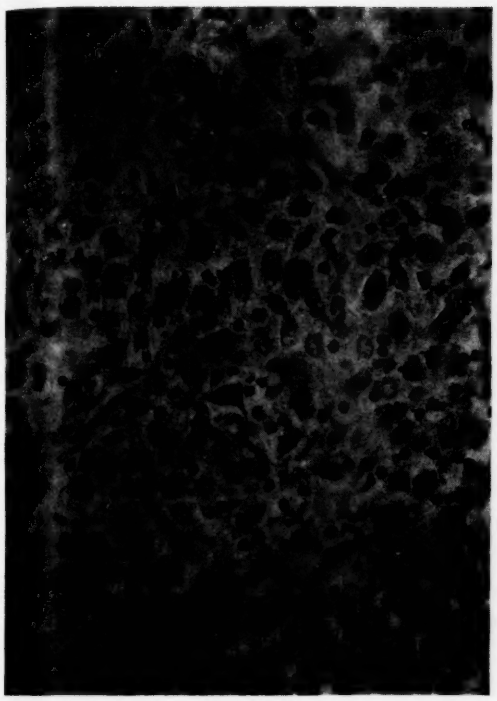

Fig. 1.
Large, pale, polygonal cells, numerous mitotic figures and variation in size and shape.

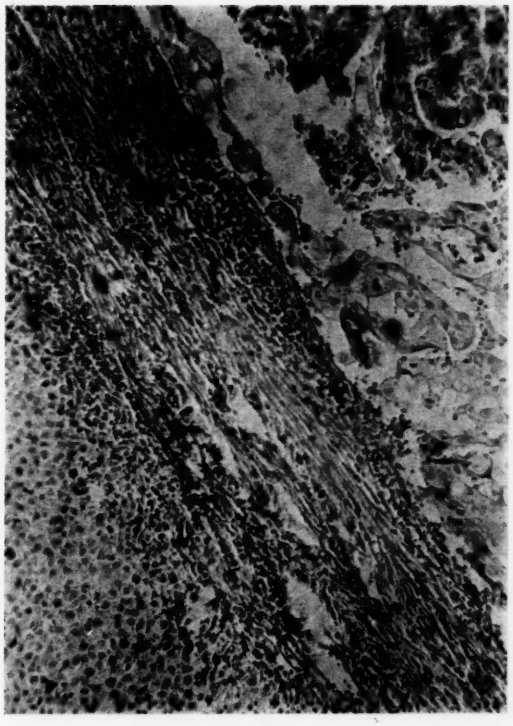

Fig. 2.
Shows section of mucosa and myometrium containing both sarcoma and carcinoma.

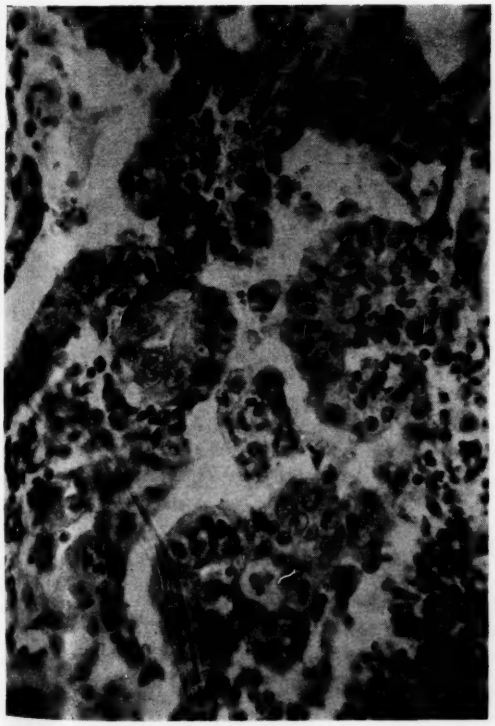

Fig. 3.
Gland-like arrangement and large atypical papillary projections with little stroma, areas show metaplasia and adenoacanthoma.

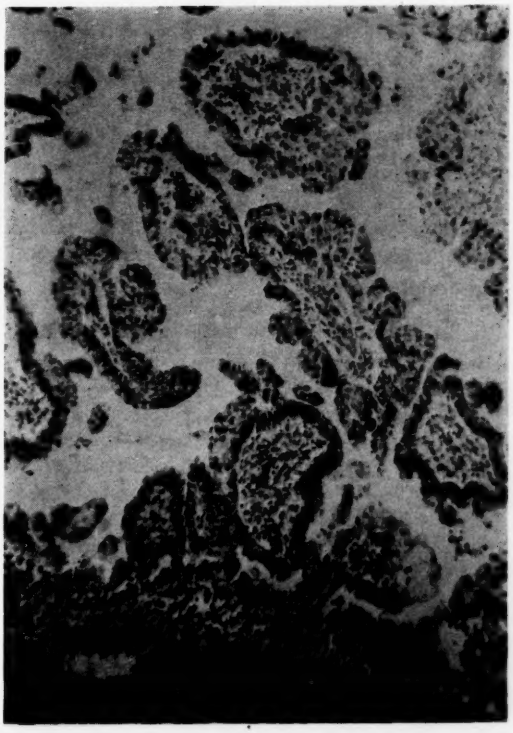

Fig. 4.
Section from endometrium shows similar changes as fig. 3.

## CO-EXISTENT SARCOMA AND CARCINOMA OF THE UTERUS

*concluded from page 316*

both sarcoma and carcinoma in close proximity (see figure 2.) The sarcoma shows a definite lining by a layer of mucosal cells and includes an occasional endometrial gland. A small nodule of sarcoma is seen within the myometrium at a distance from the surface. The adjacent mucosa also shows definite neoplastic changes. The glands are arranged in large atypical papillary projections with hardly any stroma. They are lined by several layers of cells, exhibiting marked variation in size and shape, hyperchromatic nuclei and many mitoses. There are many areas with squamous metaplasia, adenoacanthoma (see figure 3.) Occasional groups of glands have penetrated into the myometrium. Section from a distant portion of endometrium, left lateral wall near internal os, shows similar changes (see figure 4.)

### *Comment*

The acanthomatous features of the adenocarcinoma produce a picture of marked anaplasia which, however, does not reflect the true degree of malignancy. Still, there are enough other factors to distinguish this simple hyperplasia or atypical proliferation. The tumors are obviously separate entities, one arising as a bulky mass with demonstrated spread to the underlying myometrium, the other occupying the endometrial surface. The histological features of the sarcoma point to an endometrial origin, which is in agreement with all previous cases reported.[3,4,5,6,7,8] There are no distinct clinical features beyond those of malignancy to indicate the presence of the two different types of tumors and even a biopsy can be unreliable.

### *Summary*

A case of sarcoma and carcinoma arising in the same uterus is reported and the histological features evaluated.

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## HOMO MEDICUS

*concluded from page 311*

upon whose deliberations one weighs heavily, the Delegates from each district society, and all, who by endorsement or constructively critical dissension, in these Providence Plantations, aided in our progress and advancement.

The question for the immediate future is how can we best serve the interests of the American People? And I say to you that we can do this only by procuring better things for better living through medicine. The late President Lowell of Harvard University once said rather succinctly: "It is hardly an exaggeration to summarize the history of the last four centuries by saying that the leading idea of the conquering nation in relation to the conquered was in 1600 to change their religion; in 1700 to change their laws; in 1800 to change their trade; and in 1900 to change their health. On the prow of the conquering ship in these four hundred years, stood first the priest, then the lawyer, then the merchant, and today the physician." And now, gentlemen, as I take leave of the pleasures of this office let me extend a final word of sincere thanks to all my colleagues, whose loyal support has made my tenure an inspiring privilege and an indelible memory.

# CONGESTIVE FAILURE AND LIVER DYSFUNCTION*

ANTHONY CAPUTI, M.D. AND DAVID LITTMAN, M.D.

The Authors. *Anthony Caputi, M.D., Assistant in Medicine, Newport Hospital, Newport, R. I. David Littman, M.D., Cardiologist, Veterans Administration Hospital, West Roxbury, Mass.*

IN EXTENSIVE heart failure hepatic congestion is the rule. Despite this, jaundice is rare together with cardiac decompensation. When it does appear, it is thought to result from coincidental acute or chronic liver disease or from extensive hemolysis such as occurs with pulmonary infarction. It is apparent, even to the casual observer, however, that individuals exhibiting icterus during the course of heart failure commonly respond poorly to treatment and exhibit a high mortality. The customary course of such patients suggests that jaundice represents an ominous complication or manifestation of heart failure. It is not always plain, however, whether icterus marks a malignant or irreversible stage of failure or whether it indicates the presence of a second coincidental disease which serves to exaggerate the cardiac disturbance and to interfere with successful therapy. The latter possibility is supported, at least in part, by the alteration of serum proteins which results from hepatic dysfunction and which serves to increase the retention of fluid.

Paine and Smith[1] who studied this problem concluded that jaundice in congestive failure results from hepatic anoxia caused by pulmonary infarction. This in turn leads to altered metabolism of the hemoglobin breakdown products from the infarct and elsewhere. However, since pulmonary infarction unassociated with myocardial incompetence does not ordinarily lead to jaundice, it must be assumed that additional hepatic changes during failure must be blamed on congestion. Other possibilities which have been considered are oxygen unsaturation, toxemia, and the coincident presence of primary hepatic disease such as portal cirrhosis. An interesting but somewhat mechanistic theory which rather fits the observed retention of direct bilirubin concerns the physical collapse and occlusion of bile capillaries. This is thought to result from a degree of intrahepatic congestion which still permits functional integrity of the liver cells.

It appears unlikely that icterus during heart failure results from the abnormal metabolism of blood breakdown products. This was well shown by Rich and Resnik[2] who injected 100 cc of blood into the thighs of decompensated subjects without altering the serum bilirubin levels. These investigators believed that the mechanism was related to oxygen deficiency rather than to pulmonary infarction per se.

Similarly, Bernstein and his associates[3] considered that arterial anoxia was an important cause. They arrived at their conclusions by demonstrating significant bromsulphalein retention in patients having essentially pure left-sided failure. This appears eminently reasonable in view of the fact that the hepatic artery contributing only some 25% of the total blood supply of the liver provides the major portion of the oxygen. Conversely, they found that the rise in intrahepatic pressure coincident with right-sided failure did not further alter the BSP retention.

As the result of their studies Chavez and his co-workers[4] concluded that the amount of bilirubin and bromsulphalein retention and the height of urinary urobilinogen were parallel to the degree of heart failure.

It is of interest to note that jaundice in congestive failure is not as rare as is generally supposed. Foley[5] found clinical jaundice in 11 of 30 patients with heart failure. Similarly, Cantarow[6] found abnormal BSP retention in 1/3 of 42 such patients. However, only 2 were visibly jaundiced while 8 had abnormal bilirubin levels. Moses[7] who studied 354 consecutive patients showing aberration of liver tests found that 35 were individuals with cardiac decompensation. Of these, 19 had increased bromsulphalein retention and 11 abnormal cephalin flocculation tests. Five of the 35 had clinical icterus.

It is apparent from the views of these authorities that there is no unanimity of opinion regarding the causes or even the incidence of congestive failure with jaundice. The rather poor prognosis has not been stressed. Following is a case report illustrative of the series reviewed at this hospital.

*continued on next page*

* From the Medical and Pathological Services, Veterans Administration Hospital.
Sponsored by the Veterans Administration and published with the approval of the Chief Medical Director. The statements and conclusions published by the authors are a result of their own study and do not necessarily reflect the opinion or policy of the Veterans Administration.

### *Case Report*

A 56-year old white male first noted the onset of severe substernal pain and shortness of breath in 1945. A diagnosis of coronary occlusion was made during hospitalization. Persistence of the symptoms of congestive failure and coronary insufficiency resulted in the curtailment of work in 1947 and the continuation of nitroglycerine and digitalis therapy. During October 1948 he was hospitalized and the diagnosis of hypertensive and arterioslerotic heart disease was confirmed. There was evidence of cardiac enlargement and posterior myocardial infarction. The terminal admission in November 1948 was precipitated by massive leg edema, ascites and right upper quadrant pain.

Physical examination on his admission to this hospital in November 1948 revealed slight distension of neck veins. There was no cyanosis. There were a few fine inspiratory rales at the lung bases. The heart was enlarged and the apical impulse was palpated in the fifth left interspace 1 cm. beyond the midclavicular line. The rate was 112 and the rhythm regular. The heart sounds were normal, and there were no murmurs. Blood pressure was 150/100. The abdomen was moderately distended and tense with the presence of fluid. The liver was smooth and tender, and the edge was palpated nine finger breadths below the right costal margin in the midclavicular line. There was four plus pitting edema of the lower legs and two plus of the upper thighs.

The hospital course was downhill with rapidly progressing congestive failure. There had been a 32-pound weight gain since the admission one month prior. Because of the markedly enlarged and tender liver, liver studies were performed. The cephalin flocculation test was 3 plus in forty-eight hours. The prothrombin percentage was 16% (34 seconds) as compared to a control of 15 seconds. The Van den Bergh was 1.0 mg% with 0.8 mg% in the direct phase. The urinary urobilinogen concentration was 1:10. On December 9 clinical jaundice became manifest for the first time. A serum bilirubin level was 6.6 mg% with 5.4mg% in the direct phase. He died on December 10.

Postmortem examination revealed hypertensive and arteriosclerotic heart disease with cardiac hypertrophy (590 Gm.) and old posterior and middle septal myocardial infarctions. There was moderate pulmonary congestion and edema. There were two fresh infarcts of the left kidney secondary to deep arterial thrombosis. The liver weighed 2410 Gm . . . Microscopic examination revealed marked central hemorrhagic congestion and necrosis.

### *Comment*

The material for this paper was compiled from the files of the Veterans Hospital, West Roxbury, Massachusetts, during the two-year period from January 1948 to January 1950, and included all the cases of congestive heart failure in which one or more liver tests had been performed. These totalled 83 cases, 30 of whom died. Of the 25 cases in which postmortem examinations were performed, three were excluded because of major liver pathology unrelated to the congestive failure. This study was undertaken for the purpose of adding to the available information relative to congestive failure with jaundice.

Of the fifty living patients there was aberration of liver tests in fifteen. The prothrombin time was prolonged in ten. The cephalin flocculation test was recorded from 2 to 4+ at the end of forty-eight hours in seven. In four cases the total Van den Bergh varied from 1 to 1.4 mg%, with the major portion in the direct component; these patients were clinically jaundiced.

It was impossible to determine the duration of congestive failure, but for purposes of study the classification used was minimal, moderate and mild. There was not, however, any correlation of the degree of congestive failure with liver dysfunction or degree of liver enlargement, and in three cases the liver was not palpable. In twelve cases hepatomegaly varied from one to six finger breadths below the right costal margin. Two cases had superimposed pulmonary infarction, one with a recorded Van den Bergh of 1.4 mg%.

In the 23 cases in which postmortem examination was performed, liver tests had been performed in eleven. As in the group of living patients the most commonly altered test was the prothrombin time which was prolonged in nine. In eight cases the cephalin flocculation test varied from 3 to 4+ in forty-eight hours. In six patients the Van den Bergh varied between 2 and 3.4 mg% with the major component direct; all six were clinically jaundiced.

There was direct correlation between the clinical estimate of liver size by palpation of the liver edge below the right costal margin and the actual postmortem weight of the liver. The palpatory liver size varied from two to eight finger breadths below the right costal margin, with the majority in the four finger breadth range. Most of the living patients, however, had liver edges which were palpable less than four finger breadths below the right costal margin.

Hepatic pathology in the presence of heart failure varies in its severity with the extent and duration of the myocardial incompetence. The least and earliest changes consist of centrolobular congestion. This is followed by necrosis and liver cell atrophy. The late picture is that of central fibrosis of the hepatic lobule. Katzin and his associates[8] found hepatic fibrosis of the central type (one exception) in 33% of 286 patients who came to autopsy with chronic passive congestion of the liver. They considered that cardiac cirrhosis could

occur in 50% of cardiac subjects who had congestive failure lasting 9 months or longer.

Microscopic findings showed changes which varied from slight central congestion to central fibrosis. The microscopic sections of four livers were normal in appearance. The predominant pathologic lesion was centrolobular congestion with or without atrophy of the central hepatic cells. This finding was observed in 17 cases. One section was interpreted as showing central fibrosis, and another as centrolobular fatty metamorphosis.

Several broad conclusions may be drawn from these data. The association of jaundice and congestive failure appears to be a poor prognostic sign, since six of the dead (22 cases) and three of the living (50 cases) exhibited jaundice that was verified by an elevated serum bilirubin. The extent of liver edge descent below the right costal margin appears to serve as a rough sign for the prediction of liver test aberration and degree of microscopic liver damage. It would appear that the clinical observation of jaundice combined with a moderate degree of hepatomegaly (liver edge greater than three to four finger breadths below the right costal margin) would indicate a grave prognosis. The available data were not sufficient to draw any valid conclusions regarding the direct cause of jaundice during congestive failure. However, its presence commonly foreshadows a fatal termination.

*Summary*

In an analysis of 83 fatal and non-fatal cases of congestive failure in which liver tests were available in the period from January 1948 to January 1950, at the Veterans Hospital, West Roxbury, Massachusetts, the following conclusions are reached:

1. The association of jaundice and hepatomegaly in congestive heart failure indicates a poor prognosis.

2. The degree of hepatomegaly appears to correlate well with the degree of microscopic liver damage and liver dysfunction.

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# The RHODE ISLAND MEDICAL JOURNAL

*Owned and Published Monthly by the Rhode Island Medical Society,*
*106 Francis Street, Providence, Rhode Island*




## THE MEDICAL SOCIETY DISAPPROVES

DURING the legislative session of the Rhode Island General Assembly, recently concluded, a bill was introduced and passed that would amend the workmen's compensation act to provide that "the charge for hospital services shall not exceed the established rate customarily charged by the hospital rendering such services to private patients occupying ward accommodations, and that the portion of such charge covering room, board and general nursing care shall not exceed $14.00 per day."

The proposed amendment was vetoed by Governor Dennis J. Roberts, and one of his reasons for his action, as quoted in the daily press, was because the "medical society disapproves of the measure."

Governor Roberts is to be highly commended for his action in vetoing this measure in spite of the pressure that must have been placed upon him to allow it to become law. We know that he did not act merely because the medical society had expressed an opinion on the proposed law. We know that he, too, saw the wide implications in the act that seriously affected all the citizens of Rhode Island.

The Committee on Public Laws of the Society reviewed all health legislation before the Assembly, and made known its views on many proposed acts. In its statement to the Assembly committee, to the leaders of both parties in both the House and Senate, and to the Governor, the Society's committee pointed out dangers inherent in the hospital cost measure, and it urged that the adoption of the amendment be delayed until the Assembly had the benefit of the findings of the study currently being undertaken by the Committee on the Cost of Hospitalization.

The Society's committee pointed out to the Assembly that the enactment of the increase in per diem ward rate for beneficiaries of workmen's compensation provisions would set a standard that could become the basic cost for all ward patients in all hospitals, thus resulting in the increase of hospitalization expense for everyone. With no hospital in the State at this time charging more than $12 for a ward bed, the offer to allow up to $14 under the workmen's compensation act would be an open inducement to increase to that rate.

We have made the Rhode Island Blue Cross the most successful hospitalization insurance plan in the country. Much of that success stems from the whole-hearted cooperation of industry in this State in providing at the employer's expense for employee hospitalization insurance. Industry must pay the entire cost of workmen's compensation insurance, too, thus in a fashion providing double coverage for a large segment of the population as regards hospital insurance. How long it can accept this burden will depend upon the concerted action of all community groups to keep the costs within reason.

The Committee on the Cost of Hospitalization in

Rhode Island is engaged in a fact finding study to assist the hospitals and the people of this State to arrive at a definite knowledge of the future cost of hospital care. The General Assembly has established a new commission to review the entire workmen's compensation program and to report next year. With these two mechanisms in operation Governor Roberts acted in the best interest of the people when he vetoed the workmen's compensation amendment.

## LIABILITY INSURANCE

The recent court case in which a physician was sued for fifty thousand dollars on a malpractice claim illustrates again the importance to every physician of keeping accurate records on every patient, and in addition in maintaining an adequate liability insurance coverage.

Most physicians purchase insurance when they first start practice, and merely renew the policy from year to year without giving consideration to the importance of extending the coverage. Alert insurance agents may have convinced many physicians of the importance of increasing their liability protection, but we fear that many of our members have either turned a deaf ear to the agent, or have left their policy in a safe deposit box in the belief that the protection is adequate.

The five thousand dollar liability for one claim, and fifteen thousand aggregate for any one year is hardly sufficient today when one considers the initial sums which are asked for damages in threatened suits. The rates have increased with many of the companies, but the increase is not of any sizable proportion for coverage permitting the physician to feel adequately sure that his malpractice insurance is sufficient to meet any possible claim.

We are not trying to sell insurance in this plea to our members to review their liability policies. We merely suggest that each member take a look at his present coverage, place himself in the position of facing a jury trial for a fifty thousand dollar claim, as happened here recently, and the answer will be readily apparent as to the cash loss that would be incurred to the individual physician should a decision go against him.

## DIATHERMY REGULATIONS

Our attention has been called to the fact that many physicians are being urged to replace their diathermy equipment because of regulations adopted a year or more ago by the Federal Communications Commission that will go into effect in June, 1952, a year hence.

Our advice is that you do not act hastily in replacing your present equipment. Your present diathermy machine can be operated after June 30, 1952 *provided* such operation complies with provisions established by the Federal Communications Commission which were published a year ago in our August, 1950, issue of the Rhode Island Medical Journal. Under these regulations (Section 18.11 and 18.12) provision is made for the operation of diathermy equipment designed to operate within the allocated bands and outside the allocated bands respectively.

A copy of these regulations will be made available to any member on request, or they may be read at the Medical Library by consulting the bound issues of our Journal for 1950.

## NATIONAL HEALTH INSURANCE: ITS ADVANTAGES AND DISADVANTAGES

Elsewhere in this issue is an article by Dr. Channing Frothingham, Chairman of the Committee for the Nation's Health and proponent of National Health Insurance.

Dr. Frothingham's committee has loudly and frequently complained that doctors opposed National Health Insurance only because they did not understand it and were unable to have both sides presented to them in the Medical Journals.

The Journal of the American Medical Association is the official organ of the House of Delegates of the American Medical Association and must necessarily report and reflect their views. The delegates of the American Medical Association are truly representatives of Medicine, and any member of the American Medical Association can appear before the reference committees of the House and be heard if he desires to influence the thinking of the American Medical Association.

The Medical Journal of the several states are likewise the creatures and the official organs of the medical profession of the states and do no injustice to a minority group by refusing to open its pages to all and sundry.

Rhode Island long noted for its independence has always been willing to give an impartial ear to both sides and has always reported all developments of the National Health Program.

In January, 1946, we published an address by Arthur J. Altmeyer (then chairman of the Social Security Board) on this subject. On four different occasions proponents of National Health insurance have had a public forum in Rhode Island with our active participation.

Dr. Ashworth met Dr. Frothingham and Dr. Farrell met Dr. J. H. Means and Dr. Young. Also Drs. Young and Butler were on a radio program with Dr. Farrell and Dr. Ashworth. We doubt if any greater opportunity to tell their story was ever given them than Rhode Island Medicine has offered. We do not believe that the medical profession in Rhode Island opposes Socialized Medicine or National Health Insurance because they never

*continued on next page*

had a chance to hear the other side, and we open our columns for one final gesture toward those who would accuse the official Journals of gagging them.

We dare open our columns to the proponents of National Health Insurance because we have no fear of our ability to completely and thoroughly refute their every argument and do so effectively enough to prove that Rhode Island Medicine still opposes National Health Insurance.

Most of our doctors are thoroughly familiar with the attitude of our leaders regarding this subject. We therefore cross the continent and ask Dr. Lowell Goin of California to reply to Dr. Frothingham. We hope every doctor in Rhode Island will read their articles, and we further hope that it will once and for all prove to the proponents of National Health Insurance that we do not fear to have their philosophy broadcast to the whole profession.

*Providence Journal Photo*

**NEW PRESIDENT**

**Dr. Charles J. Ashworth, left, retiring president, turns over the gavel of Presidency of the R. I. Medical Society to Dr. Herman A. Lawson.**

## GENERAL MEETING . . . MAY 10, 1951

A general meeting of the Rhode Island Medical Society was called to order by the President, Dr. Charles J. Ashworth, at 12:15 p. m. on Thursday, May 10, 1951.

Doctor Ashworth read the section of the by-laws of the Society relative to the general meeting, and he urged that members avail themselves of the opportunity in the future to present matters to the membership at this meeting, or to make recommendations to the House of Delegates.

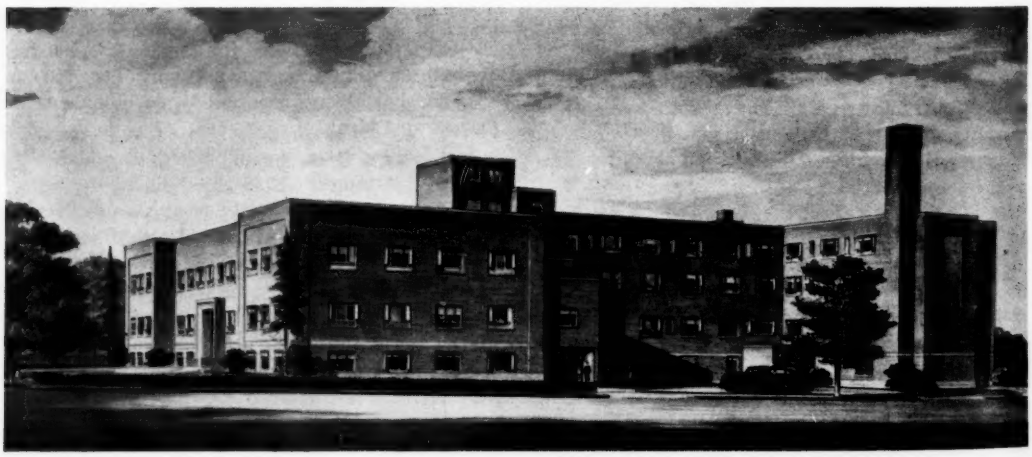
The Secretary, Dr. Morgan Cutts, reported on the action of the House of Delegates whereby a slate of officers and standing committees had been elected to serve for the twelve month period from this date until the annual meeting in 1952.

Dr. Herman A. Lawson, president-elect, was escorted to the platform by Drs. Marshall N. Fulton and Joseph G. McWilliams, and he addressed the members briefly asking for their continued active support in the work of the Society.

The other officers elected by the House of Delegates were recognized. There being no new business presented for action the meeting was adjourned at 12:45 p. m.

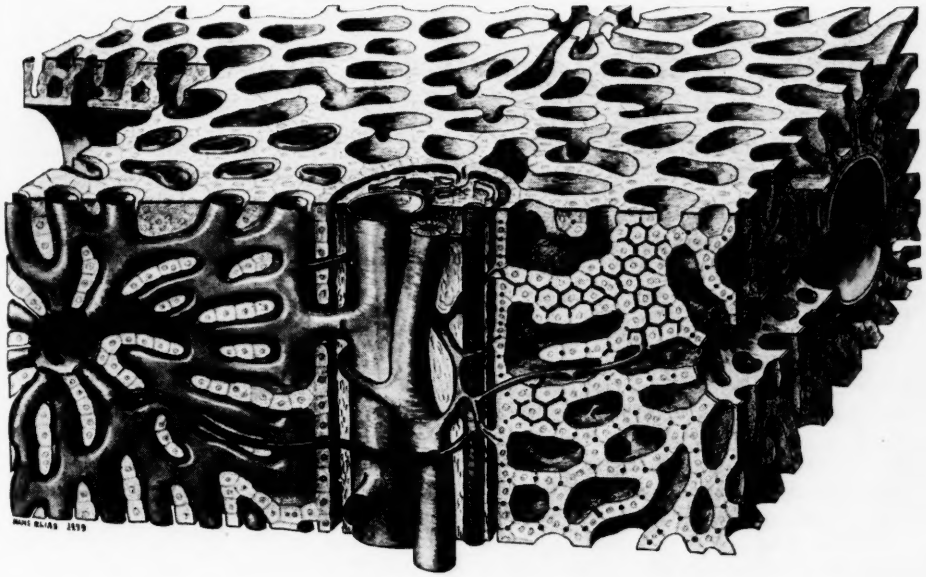
Respectfully submitted,

MORGAN CUTTS, M.D., *Secretary*



**NEW MIRIAM HOSPITAL**

**The cornerstone for the new Miriam Hospital was laid on Sunday, May 20, 1951. Among the documents deposited in the record box was a copy of the May issue of the R. I. Medical Journal.**



**The Liver Lobule...** The functional unit of the liver, the lobule, is the starting point in gallbladder therapy. Its cells secrete the bile for passage through the ductal system after collection in the lobule tubules.

**KETOCHOL®...** a combination of all four of the oxidized, unconjugated bile acids normally present in human bile—initiates gallbladder therapy at its logical starting point. The primary action of Ketochol is on the hepatic cells which are stimulated to secrete bile of low viscosity that flushes the congested ducts.

RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

# ANNUAL DINNER MEETING
## *of the*
## RHODE ISLAND MEDICAL SOCIETY
### *At the Narragansett Hotel, May 9, 1951*

**Introductions and Remarks of Anniversary Chairman, Mayor Walter H. Reynolds, Dr. Hobart A. Reimann, Chapin Orator, Governor Dennis J. Roberts, Dr. Charles J. Ashworth, President of the Society, and Dr. Edward J. McCormick, Speaker.**

**CHARLES L. FARRELL, M.D.**
***Anniversary Chairman***

The story of Dr. Charles Value Chapin is well known to all of us. Equally well known to us is the annual Chapin oration. From the inception of this Award in 1942, the Chapin orators have been men of outstanding reputation, leaders in the profession, and widely acclaimed for their contributions to medicine, long before they came to Providence. This year's orator is no exception.

This is the occasion of the Tenth Annual Chapin Oration. For the presentation of the Chapin Award tonight to Dr. Hobart A. Reimann of Philadelphia, who today delivered the oration for 1951, I now call upon the Honorable Walter H. Reynolds, Mayor of the City of Providence.

**HONORABLE WALTER H. REYNOLDS**
***Mayor of Providence***

Mr. Toastmaster, The Very Reverend Father Slavin, our distinguished President of Providence College, Your Excellency Dennis J. Roberts, Governor of the State of Rhode Island, Distinguished Members of the medical profession and their wives, and all of the distinguished ladies and gentlemen present here tonight.

It seems to me that one of the most fitting things ever done by the City of Providence was the establishment of the Charles V. Chapin Award, which I have the honor to present here this evening.

By the annual presentation of this Award to an outstanding member of your great profession we help to perpetuate the memory of one of the most distinguished sons that Providence ever produced.

As Mayor perhaps no layman can appreciate more keenly than I do the tremendous contributions of Dr. Chapin, both in medicine and in the effective administration of the functions of government. His contributions to the techniques of control in communicable diseases are well known to all of you. They made history, and they have been the foundations upon which modern public health authorities have built their systems of keeping communicable diseases in check.

The people of Providence and the people of civilized communities all over the world stand deeply in Dr. Chapin's debt. Millions of people across the world are alive today because of the work that he did to make epidemics a modern rarity. The broad gauge of Dr. Chapin's ability is emphasized by his administration of accomplishments as Superintendent of Health in Providence for forty-eight years. He not only set up our first full-fledged Health Department, but he also organized the recording of vital statistics, which tell so much of the story of medical progress in this community.

You, the members of the Rhode Island Medical Society and the Providence Medical Association, are the people who are writing that story today. The decline in recent years in the death rate and the general high level of health that we enjoy today are attributed to the work that you are doing.

It so happened that just a few weeks ago, I was present at the Civil Defense meeting, where a distinguished member of that Committee suddenly became ill. I don't need to tell you that we wanted a doctor, and we wanted one right away. I am happy to say that a doctor was there, within a matter of minutes. John E. Farrell, your Executive Secretary, put in an emergency call to the Medical Bureau, and almost immediately a physician appeared on the scene. If the medical profession meets its public responsibility as effectively as it did that day, I think that we need have little fear of what some prophets describe as a dark future for private medicine. And that is especially true, also, when private medicine continues to produce physicians of the calibre of Dr. Hobart A. Reimann, whom we honor here tonight.

As Magee Professor of the Principles and Practice of Medicine at Jefferson College, as Medical Officer of UNRA Study in China, and as an author of techniques which have enlarged the body of scientific medical knowledge, Dr. Reimann has distinguished himself among the members of the distinguished medical profession.

*continued on page* 328

## ANNUAL DINNER

*continued from page 326*

In memory of Charles Value Chapin I have the honor, Dr. Reimann, to present to you, now, on behalf of all the people of Providence, this Award. With it go our congratulations on your past achievements, and our very best wishes for many years of future distinction in the field of Medicine.

### HOBART A. REIMANN, M.D.

Mr. Toastmaster, The Very Reverend Father Slavin, Your Excellency the Governor, His Honor the Mayor, Ladies and Gentlemen. This is, indeed, an embarrassing moment for me. I have never received a medal before.

I have been trying to discover, this evening, why I was selected to receive this honor, and I don't know why it was. As Professor of Medicine, I should think that it would be the job of any Professor of Medicine to do something new, from time to time, and I really don't see why he should get a medal for it, because it is his job to do that.

However, in discussing this matter with Dr. Lawson and Dr. Cutts a few minutes ago, I gathered that it was for my interest in the viral dysentery in 1940 and some other things that aren't so nice to talk about in an audience of this kind. Just the same, I am sure that it was not for the subject I discussed this afternoon, for that is a rare disease and no one has as yet confirmed it, and the idea might be entirely wrong.


*Providence Journal Photo*

**CHAPIN MEDAL AWARDED**

**Dr. Hobart A. Reimann, of Philadelphia (right) receives the Dr. Charles V. Chapin Memorial Award of the City of Providence from Mayor Walter H. Reynolds while Governor Dennis J. Roberts observes the presentation.**

However, I am most grateful for the Award, and I thank you very much for it.

In regard to Dr. Chapin's contribution, something that His Honor, the Mayor, did not mention was the fact that his ideas have dominated the field of infectious disease and epidemiology ever since he published them years ago. There has been practically nothing changed, which has changed our ideas about viral pneumonia, for instance. As a matter of fact, he only made one error, which I discovered in reading this pamphlet, published by the Metropolitan Life Insurance Company, in which he is regarded as one of the twelve heroes of American Public Health work. His only error, and it is, perhaps, quibbling, to mention it now, was the fact that he thought that respiratory type of disease, or any infectious type, could not be transmitted by the breath or the air. For, I thought of my own experience in the theatre, when I saw Maurice Evans portraying King Henry *IV*, in which he makes the statement: "I spit on you." I think it occurs in that play. At any rate, he was on a darkened stage, and the spotlight came across him, and one could see the droplets of saliva exuding.

Dr. Chapin thought that the danger of contracting infection was one foot. But, actually, we could see this eight feet from him. That is not the only importance of the thing, as far as infectious disease is concerned, for we know that since the discovery of the air centrifuge that any person coming in with a cold expels the saliva into the air, containing these droplets of the virus, which dry, and leaving the particles floating about in the air, much like tobacco smoke does, and any one coming into the room is liable to get it.

So that that is the only thing that he forgot. But, that is a small point, and could only have been discovered after the air centrifuge was used.

So Dr. Chapin's contributions, for which I am doing him the honor today, in this lecture, did really establish something great in the field of infectious disease, for which we are all grateful, and, as I have stated before, his work has colored all of our lives of those of us who are interested in infectious diseases.

I want to thank the Society and the City for the great honor bestowed upon me here today. Thank you very much!

### INTRODUCTION OF GOVERNOR ROBERTS BY CHAIRMAN CHARLES L. FARRELL, M.D.

The general health and welfare of the people en masse are a part of our responsibility in the practice of medicine, and we stand ready to advise and assist in any way possible, according to our ability and training, for the benefit of all citizens, whether to the Governor, the Legislature, hospital or lay groups.

*continued on page 330*

# *Outstanding results with Furacin*

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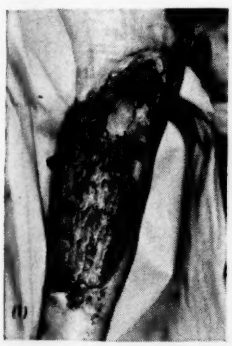
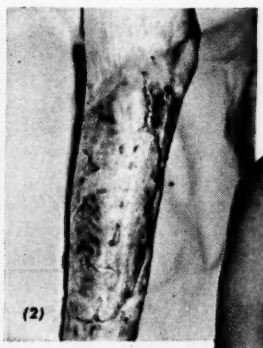
*for example:*

## IN TRAUMATIC INJURY



(1)



(2)

Injury 15 years previously, of the right leg of a man 45 years old, had never healed.

There was extensive superficial ulceration and profuse purulent discharge with P. aeruginosa (pyocyaneus), P. vulgaris, diphtheroids, Streptococcus pyogenes, Micrococcus pyogenes albus. *See 1 above.*

*December 4.* Furacin Soluble Dressing was applied twice daily with gauze covering. Discharge soon decreased and granulations were filling in. Fibrous tissue was curetted and the lesion skin-grafted. Furacin Soluble Dressing was continued. There was a favorable percentage of "take."

*January 7.* Patient discharged. *(2)*

*Literature on request*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## ANNUAL DINNER

*continued from page 328*

Our Legislative Committee reviews legislation, but our comments at all times are directed towards the welfare of the people we serve and are never pointed to our own selfish interests. We hope our Governor and Legislators will call upon us for service, whenever needed, and we are glad to take this opportunity to congratulate our Governor upon the brand of statesmanship he has shown so clearly, as Governor, and as Mayor of the City of Providence.

For me to attempt to introduce the Governor would be rather silly because he needs no introduction; every one knows him, and most of you know him personally.

May I simply say that we are proud and happy to have with us tonight a man who has a place in the hearts of all of us, His Excellency Dennis J. Roberts, Governor of the State of Rhode Island and the Providence Plantations.

### His Excellency Dennis J. Roberts

***Governor of Rhode Island***

Dr. Farrell, The Very Reverend Robert J. Slavin, President of Providence College, His Honor, the Mayor of Providence, Dr. Reimann who was given the Chapin Award, Dr. Edward J. McCormick, our guest speaker of the evening, distinguished guests, officers and members of the Rhode Island Medical Society, ladies and gentlemen. I am very grateful to the Society for extending to me the courtesy of joining with you this evening at the presentation of the Charles V. Chapin Award to Dr. Reimann for his outstanding service to the medical profession and to the welfare of our country. I express to him the sincere gratitude of the people of Rhode Island for his contributions to the health of the United States and for the welfare of our people of Rhode Island.

I should also like to have the opportunity of expressing the gratitude and the appreciation of this great State to Dr. Farrell, Dr. Ashworth and those of the Society who have been so active in the interests of the health of our people. I should like, also, to extend to the President-Elect, Dr. Herman Lawson, the felicitations and the gratitude of the people of Rhode Island on his assuming the responsibilities of the office of President of the Rhode Island Medical Society.

I feel very grateful to the medical profession of the State of Rhode Island, and I say that because of the fact that during my ten years as Mayor of the City of Providence, the second largest city in New England, and my brief experience as Governor of the State of Rhode Island, I have had the cooperation, the courtesy and the kindness of direction from the Rhode Island Medical Society, the Providence Medical Association, and from individual medical men of the profession.

As you doctors well realize, and I think that all of the people of Rhode Island have the same realization, the contributions of the medical society and the medical county societies in the communities are of inestimable value, and without those contributions, our people would perish. Without their conscientious devotion to their profession and to their people, we would have chaos throughout the great city of Providence and the State of Rhode Island, and indeed, throughout this country.

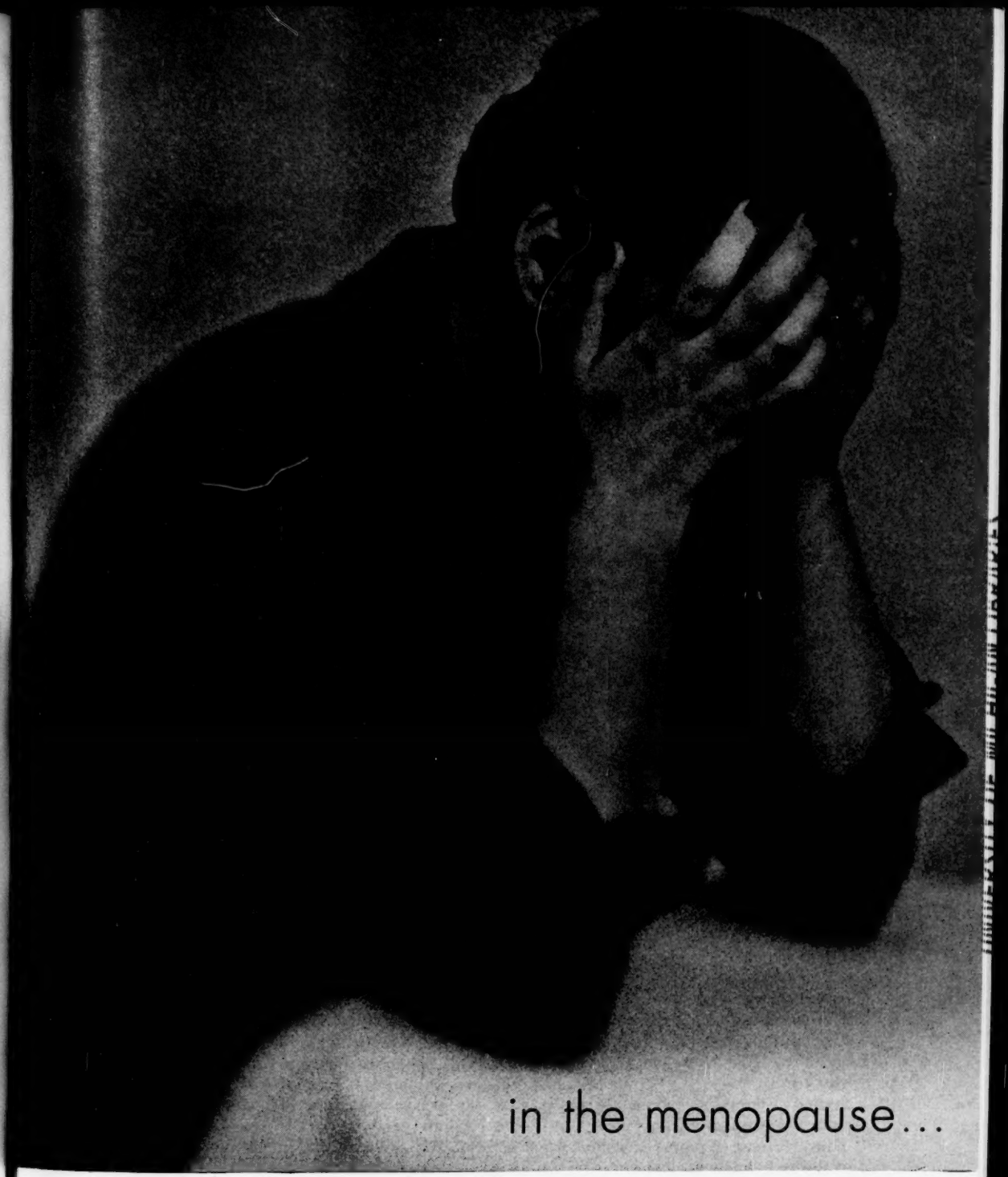
Having the opportunity during my public service to realize that the men and women who make up the medical profession in the State of Rhode Island are of a type that are over-zealous in their desire to serve their fellow men with all of the skills and techniques which they have at their command, we, of Rhode Island, are fortunate to have you gentlemen make the contributions which you have made to public health and the individual welfare of our people.

We, perhaps like other New England States, are unique in the method we have of receiving medical care. Practically all of our hospitals, perhaps with the exception of the Charles V. Chapin Hospital, are privately endowed; they are the result of benefactions of people of years ago, who had the humanitarian instinct to provide medical facilities and hospitalization for the people of our community who could not afford it. Our institutions that provide that service are a result of that charitable instinct. That is typical of the people of Rhode Island, but those institutions, without the help and without the service of the medical profession, would be empty buildings and hallowed walls. It is the very life that you bring to it, by reason of your skill and your devotion and your desire to serve your fellow men that makes this service in the State of Rhode Island, I think, of the highest standard throughout the country, and I agree with the distinguished Mayor of Providence, when he said that the people of Rhode Island and of Providence have already received the consideration, devotion and conscientious application of their talents and ability by the doctors of this community.

As Governor of the State of Rhode Island, I am very happy to have the opportunity to extend to you, on behalf of all of the people of this great State, their esteem, their appreciation of your service and the gratitude that they have for the results that you made possible in this community.

I hope that the Rhode Island Medical Society will have the opportunity of advancing and making the progress in the future that has been made in the past, because it is a Society composed of men who have devoted themselves to this community, and I am sure that as the years go by, the glory that

*continued on page 332*

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Neustaedter, T.: Am. J. Obst. & Gynec. 46:530 (Oct.) 1943

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## ANNUAL DINNER

*continued from page 330*

will be brought to this organization by reason of the character and the ability of those who make up its membership will be outstanding in the United States, and will be outstanding for the contribution and the welfare of our people.

### Introduction of Dr. Charles J. Ashworth by the Anniversary Chairman

Truly, ours is a glorious profession, though we who practice it are oft-times only subconsciously aware of it. So it is fitting and proper as scholars with a celestial intent we pause on such an occasion as this and check our collineation. The practice of Medicine is an art as well as a science but this infrangibility is not fully realized by the average individual. Too much have we suffered at the hands of crass objurgatory journalists — those despoilers of honor — integrity and virtue who glorify the commonplace — who subvert high principles for momentary temporary expediency — who mock standards in an attempt to befuddle the masses into believing their reportorial blurbs have a social consciousness.

We could exclaim with Cicero, "Oh Tempora — Oh Mores", but we in Medicine, skilled in the art of observation — reflection — evaluation and deductive reasoning — have but to apply these talents to subordinate the puny assaults on our citadel of integrity.

Medicine has an illustrious record of *social* progress as well as human betterment, but our chief fault lies in our reluctance to publicize it for fear of being charged with personal aggrandizement. That day has passed! Medicine's story must be *told!* Strong men must guide the helm. Fortunate we are, indeed, to have such men. In the last ten years your Society has been completely transformed and is a stalwart force in the community, an ever zealous guardian of public welfare and professional standards.

An eminent scholar once discoursed on the "qualities of greatness" and acclaimed them as follows:

First: Insight to see the truth and speak it fearlessly and to serve fellow man according to the light of that truth.

Second: Courage to pursue the aim in spite of all natural and unnatural obstacles.

Third: A sense of timing or instinct which allows a great man to know the moment to launch his idea.

I have neither the wit nor the words to describe the Anabasis of our next guest but I want you to know that I have had the opportunity to work closely with several Presidents of this Society and for them all I have unbounded admiration and respect. I have seen at close hand how they shouldered the many and heavy burdens of this organization — their unstinting effort to accomplish their objective — their constant self sacrifice for the medical profession of Rhode Island. But no President ever came to his post better prepared — more thoroughly versed in all the complex facets of the multitudinous problems confronting Medicine today — than does our present incumbent.

For the year before he assumed office he attended meetings and conferences in Boston, New York, Chicago, Washington and elsewhere at his own expense. He learned firsthand the basic principles of Health Insurance, Blue Cross Plans, licensure problems, hospital and professional relationships and many others.

No great deeds are done by falterers who ask for certainty! Our President has been no falterer and as a result has had at times to take the censure which is the tax one pays for being eminent. But throughout his term of office he has always displayed that gentle forbearance and tolerance which marked him as a true physician and one we can be justly proud to have represent the medical profession of Rhode Island.

Of his many efforts, one stands out above all others and may well be remembered and referred to for many years. That is the establishment of a Committee of representative citizens to explore and evaluate the cost of hospitalization in relation to our economic situation. Other states have already made inquiries regarding it and whatever its conclusions eventually disclose, the idea behind it and the social significance of the effort poignantly emphasize Medicine's eternal vigilance to the welfare of mankind.

I have thoroughly enjoyed, and will long remember, the many conferences, committee meetings and trips we had together but my pleasure is surpassed by the *pride* I feel at this opportunity to present to you now, ladies and gentlemen, a truly great man, my good friend and yours, the President of the Rhode Island Medical Society, Dr. Charles Joseph Ashworth.

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## ANNUAL DINNER

*continued from page 332*

Dr. Ashworth, on behalf of the Rhode Island Medical Society, its officers, its members, I have the honor to present you this gavel as a symbol of the authority which you wielded so wisely and well this past year. May it constantly serve to remind you of the affection and esteem with which we regard you.

**CHARLES J. ASHWORTH, M.D.**
***President, R. I. Medical Society***

Dr. Farrell, to receive this gavel as a memento of the Presidency is, in itself, a great privilege, and I would be a little less than human not to be touched by all the kind and gracious things that you have said about me. Modesty prevents me from saying they are true, but at the same time, common decency restrains my saying they are not true. I would be the last to suggest, even by implication that any member of our honored and honorable profession could, under any circumstances, be guilty of stretching the truth.

I cannot help but say to my distinguished guests, my predecessors, fellow officers, members of the Society, the auxiliary and all of our friends, that in this year in office presently ending I have had an opportunity to appraise the potentialities of the medical society, as few can.

Medicine, concerned as it is with the whole field of human welfare, from survival to improvement, without limitation of circumstances, race, religion or boundaries, has always been a social science, even before the social sciences themselves were differentiated. I think, perhaps, second only to religion has medicine exerted a powerful influence upon the objective study and understanding of human behavior.

Your medical society has extended its efforts into almost every part of this field of human welfare. The Rhode Island Medical Society's Physicians' Service, which celebrated its first birthday a few months ago, is one of the fastest growing prepaid medical care plans of this country, and is an example of what I mean, as is the committee Dr. Farrell referred to, that is studying hospital costs.

The improvement in the operation of our State disability compensation program, secured through closer cooperation with the administrator of that agency and your Committee Chairman, Dr. Pitts, extending care to the indigent and aged, is another example. And our improved public relations, not only with the press, but with the people of the state, as a result of the adoption of new techniques, by one of the hardest working and most conscientious committees of your Society, is still another example.

It would seem impossible to enumerate all of the

various works that are performed by the individuals and the committees of your Society, and I cannot help but mention your Grievance and Ethics Committee, under the able direction of Dr. Hammond, which, in this past year, has solved many serious problems.

And so, as you can see, your Society is not only a stalwart force in the community, as has been well said, but it is an ever-zealous guardian of the public welfare and professional standards.

Medicine requires of all those who are devoted to it in any noble way, the desire for and the ability to attain truth in a spirit of liberty and freedom. Irrespective of the individual, medicine reflects all that is generous in democracy. The very thoughts that are in the hearts and minds of any people, regardless of the government under which they find themselves—for we all know that the health of any people is its greatest asset—are reflected in medicine. But, I would say to you that if this freedom of medicine today, coming down to the present and projected into the future from a very cultural past, is going to be preserved, we have got to extend ourselves more, give broader cooperation and assistance to the objectives of our Society. For therein, lies the potentialities of a medical society, and not in this gavel or the individual who wields it.

### Introduction of Dr. Edward J. McCormick by the Anniversary Chairman

Before I became actively associated with the Public Relations Committee of this Society, the American Medical Association was a vague term which signified an organization in Chicago that printed a JOURNAL, operated Bureaus and Councils and was a sort of a Great White Father.

In the last few years, however, I have become more conscious of the closeness of the American Medical Association to our very lives and I deplore the fact that many of our doctors in the bustle of everyday life have no means of knowing how active a part the American Medical Association plays in medical progress. I am personally, then, very pleased that your Committee on Arrangements have included on this program a Trustee of the American Medical Association who will talk to us on that subject.

My first personal contact with a Trustee of the A. M. A. was with Dr. McCormick. It was a pleasant contact. I found him interested, sympathetic to our problems. He had a ready ear to listen and was most helpful to a newly elected Delegate. I am also happy to report that he is typical of the type of men we have as Trustees of the A. M. A. I wish each one of you could know them, have the opportunity to talk with them about the problems of Medicine, and you would glow with pride that busy, busy men can find so much time in their active lives

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## ANNUAL DINNER

*concluded from preceding page*

to look out for the affairs of Medicine on a national scale.

It has been said that if you want a thing done well, find a busy man to do it. I don't think we could find a busier one than Dr. McCormick.

I asked the Executive Office to obtain some background material for me on Dr. McCormick. They supplied me with two closely typewritten pages. It would take me fourteen minutes to read his list of accomplishments. I know. I timed it. In his busy life he has crowded a tremendous amount of work. His daily practice is that of surgery but he has found time to be interested in Red Cross — Boys Club — to serve as a member of the Board of Directors of the University of Toledo — to work on the Budget Committee of the Community Chest, on the Council of Industrial Health, and he has held many national offices with the Elks, serving as Grand Exalted Ruler for the Elks of the United States, 1938-1939. He served in the Army, the Navy, and the Public Health Service, and was awarded the Military Cross by the British Government. He has done all things well and it is a distinct pleasure to welcome to Providence and present to you Dr. Edward J. McCormick, of Toledo, Ohio, a Trustee of the American Medical Association, who will talk to us on "Democracy, Medical Progress, and the American Medical Association."

*(Editor's Note: Doctor McCormick's address will be published in the July issue of the Rhode Island Medical Journal.)*

*Providence Journal Photo*

**NEW OFFICERS**

**The new officers of the Rhode Island Medical Society, inducted at the annual session on May 10, are shown conferring on plans for the coming year. Left to right: Dr. Earl F. Kelly of Pawtucket, treasurer; Dr. Herman A. Lawson, of Providence, president; Dr. Morgan Cutts of Providence, secretary; and Dr. Edward S. Cameron, of Providence, vice president.**

# DISTRICT MEDICAL SOCIETY MEETINGS

## NEWPORT COUNTY MEDICAL SOCIETY

A meeting of the Newport County Medical Society was held on March 28, 1951. The meeting was called to order by the President, Henry Brownell, at 9:00 p.m.

The minutes of the previous meeting were read and approved.

Communications were received from the Lions and Kiwanis club and branch of P. T. A. expressing approval of toy ordinance sponsored by this Society.

After some discussion on the problems of mental rehabilitation of the alcoholic, the Society requested that it be placed on the mailing list of the Yale School of Alcoholic Studies. A letter to Mrs. O'Daniel thanking her for bringing a subject of special interest to the Society was directed.

The Society requested an application be sent to a physician on Block Island.

Mrs. Reynolds spoke briefly on the Newport Public Health Service. Dr. Charles J. Ashworth, the speaker of the evening, presented a thought-provoking paper on National Public Relations, — problems confronting medicine on a state and national level.

The Society directed the Secretary to write to Senator Pastore requesting his views on socialized medicine.

The meeting was adjourned at 10:30 p.m.

*Respectfully submitted,*

M. OSMOND GRIMES, M.D., *Secretary*

## PAWTUCKET MEDICAL ASSOCIATION

A meeting of the Pawtucket Medical Association was held at the Memorial Hospital Auditorium on April 19, 1951. The meeting was called to order by the President, Dr. Kieran W. Hennessey, at 12 noon.

The minutes of the last meeting were read by the Secretary and were accepted.

A motion was made by Dr. Earl J. Mara that the dues for 1951 remain at $15. The motion was seconded and passed.

Dr. Henry J. Hanley reported on the Benevolence Committee of the Rhode Island Medical Society. A fund is to be set up to provide financial assistance to members in need. Dr. Hanley stated that voluntary contributions will be requested in the near future.

The care of welfare patients was discussed by Dr. Charles L. Farrell. As a method of payment, he suggested the creation of a fund by the Welfare Department for this purpose. Services rendered by a physician could be reported through the Association or directly to the agency.

Dr. Farrell made a motion that members be canvassed by the Emergency Committee for volunteers to cover emergency calls. He asked also that those refusing to participate give reasons for doing so.

Attendance was 24.

Luncheon was served.

The meeting was adjourned at 12:30 p.m.

*Respectfully submitted,*

HRAD H. ZOLMIAN, M.D., *Secretary*

## PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, April 2, 1951. The meeting was called to order by the president, Dr. Louis I. Kramer, at 8:45 p.m.

The reading of the minutes of the previous meeting was omitted by consent of the members present.

The secretary reported for the Executive Committee as follows:

At a recent meeting the Executive Committee granted a one-year leave of absence to one member, and accepted the resignation of another member who has moved outside the State. Seven members were suspended from active membership for non-payment of annual dues.

The Executive Committee voted an appropriation of $200 for use by the Committee on Entertainment in connection with the annual dinner and golf tournament to be held on Wednesday, June 6, at the Pawtucket Golf Club.

The Committee authorized the joint purchase with the Rhode Island Medical Society of a motion picture projector for the use of both organizations.

To avoid a conflict with the annual meeting of the Providence Surgical Society, the Committee voted that the May meeting previously shifted back

a week to April 30, should be held on Tuesday, May 1 at the Medical Library.

Dr. Kramer reported that the committee of Drs. Arthur H. Ruggles and Elihu S. Wing, named by him to prepare the Association's tribute to the late Dr. Helen C. Putnam, has submitted its testimonial. This tribute will become a part of the Association's records.

The Secretary reported that the Executive Committee nominates for active membership in the Association the following physicians:

HENRY BABCOCK, M.D.
JACOB FELDERMAN, M.D.
JOHN F. HOGAN, M.D.
WILLIAM L. MAURAN, JR., M.D.

A motion was made, seconded, and adopted that these physicians be elected to active membership.

Dr. Kramer made the following announcements:

1. As reported by the secretary, the May meeting will be held on Tuesday, May 1.
2. Your attention is directed to the dates of the 140th Annual Meeting of the Rhode Island Medical Society, to be held here on Wednesday, May 9, and Thursday, May 10.
3. The Association's annual dinner and golf tournament will be held in June instead of September, as has been the case for the past three or four years. The date is June 6. The place is The Pawtucket Golf Club.
4. Motion picture film. . . . "Here's Health — The American Way."

Dr. Kramer introduced as the first speaker of the evening, Dr. Sumner I. Raphael, who spoke on "Cancer of the Uterine Cervix", a study of 432 cases at the Rhode Island Hospital.

Dr. Raphael stated that the ratio of carcinoma of the cervix and carcinoma of the endometrium was more or less constant at four to one respectively. Carcinoma of the cervix can occur in young girls and the prognosis in this group is poor. Ninety-eight per cent (98%) of the cases occurred in married females and it was noted that there was a definite correlation between marital life and carcinoma of the cervix. It is felt that hormonal imbalance is implicated. Fifty-six percent (56%) of the cases occurred in the post-menopausal period.

Carcinoma of the cervix is five times less common in Jewish women than in other nationalities.

Three per cent (3%) of the patients had primary maligancy at other sites.

Six out of the 432 cases were pregnant, indicating that pregnancy is possible in the presence of cancer but that the incidence is small. Abnormal bleeding in pregnancy, however, should lead one to suspect malignancy.

Proper post-partum care may prevent cancer and frequent examination of patients with a family

*continued on next page*

## PROVIDENCE MEDICAL ASSOCIATION

*continued from preceding page*

history of cancer would result in early detection.

Dr. Raphael's paper was discussed by Dr. George W. Waterman.

The second part of the program consisted of a panel by members of the fertility clinic of the Rhode Island Hospital, on the subject, "The Infertile Couple."

Introductory remarks were made by Dr. Waterman, who outlined the history of the Fertility Clinic and the obstacles its members had to overcome to reach its present status.

Dr. William A. Reid talked about the various cervical and vaginal factors that are often found in the infertile female. Infection plays an important role in this regard and the antibiotics have been very helpful in eliminating this very important factor.

Dr. Charles Potter talked about the Tubal Factor in Infertility which he regards as of first importance. He listed the several causes of occlusion of the tubes and methods of determining tubal potency. The two main methods are the insufflation of air and the instillation of radio-opaque oils.

Dr. Raphael reviewed some of the special procedures in an attempt to determine the cause of infertility. He reviewed the mechanism of ovulation. He also discussed the endometrial biopsy and culdoscopy.





Dr. Nathan Chaset discussed the Male Factor and the diagnosis of Male Infertility.

Dr. Ernest Landsteiner reviewed the causes and treatment of male infertility. He listed the causes of male infertility as follows:

1. Hormonal deficiency
2. Congenital defects
3. Infections
4. Environmental

The meeting adjourned at 10:15 p.m.

Attendance was 101.

Collation was served.

*Respectfully submitted,*

MICHAEL DIMAIO, M.D., *Secretary*

## PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Tuesday, May 1, 1951. The meeting was called to order by the President, Dr. Louis I. Kramer, at 8:35 p.m.

With the approval of the members present, the Secretary was excused from the reading of the minutes of the previous meeting.

The Secretary reported that the Executive Committee recommended for election to active membership Dr. Albert F. Rocco, and Dr. John M. Vesey, both of Providence. It was moved that these physicians be elected to membership. The motion was seconded and adopted.

The Secretary reported that Dr. Gesell of Yale would address the annual meeting of the Crippled Children and Adults of Rhode Island, to be held on Monday, May 7, at Pembroke Hall, and he reported that members of the Association are cordially invited to attend this meeting.

Dr. Kramer called attention to the program for the 140th Annual Meeting of the Rhode Island Medical Society, to be held May 9 and 10, and urged the members to attend.

Dr. Kramer also reported that the Annual Dinner and Golf Tournament of the Association would be held on Wednesday, June 6, at the Pawtucket Golf Club, and complete information on the program will be sent to each member in the immediate future.

Dr. Kramer then introduced Dr. William O'Connell, Assisting Visiting Physician, and Chief, Department of Arthritis, St. Joseph's Hospital, as the first speaker of a group discussing the subject of ACTH and Cortisone.

Dr. O'Connell spoke about their experiences with Cortisone and ACTH in 148 cases of arthritis. The cases were broken down as follows:

| | |
|---|---|
| 1. Rheumatoid arthritis | 126 cases |
| 2. Mixed or impure arthritis | 7 cases |
| 3. Frozen shoulder | 7 cases |
| 4. Gout | 8 cases |

Results with subcutaneous Cortisone showed

marked improvement in the absence of bony ankylosis. Improvement was noted one to four days after treatment was started. Return of muscle power was noted two to three months after the institution of therapy.

1. 62 patients were rehabilitated
2. 45 patients showed marked clinical improvement
3. 15 patients were symptom free

Only nine cases developed edema but no significant changes in electrolytes were noted. Three of the patients were diabetics and during treatment needed two times more insulin than before or after the use of Cortisone.

The second speaker of the evening was Dr. Frederic R. Riley, visiting physician and chief of the department of allergy at St. Joseph's hospital, who discussed asthma.

Dr. Riley pointed out that ACTH was used in cases of asthma that were intractable to the usual measures. He noted that the results were best in patients who developed asthma late in life. In general, however, his results were not as promising as the original reports.

Dr. James F. Hardiman, assisting visiting physician and assistant chief of the department of hematology at St. Joseph's hospital was the third speaker of the evening. He spoke on blood dyscrasia.

Dr. Hardiman outlined the use of ACTH and Cortisone in nine cases of blood dyscrasia. The cases were as follows:

| | |
|---|---|
| 1. Leukemia | 6 cases |
| 2. Multiple myelomas | 1 case |
| 3. Vascular purpura | 2 cases |

The cases of vascular purpura showed a dramatic response to the ACTH therapy,—100 mgs. daily for 15 days. Some of the leukemia cases showed a good response for a short time.

The papers were discussed from the floor by several members.

The meeting adjourned at 10:20 p.m.

*Respectfully submitted,*
MICHAEL DIMAIO, M.D., *Secretary*

# PREGNANCY BENEFITS UNDER STATE CASH SICKNESS PROGRAM CHANGED

PAYMENT of benefits during and immediately following pregnancy has constituted a serious economic impact on the Rhode Island Cash Sickness fund and has presented difficult administrative problems to the Department of Employment Security. They were the major cause of deficits incurred, representing over thirty per cent of the entire cost of the program for the 1949-50 benefit year. These payments have long been the subject of special study and this year were the subject of definitive action by the General Assembly.

This action constituted the most important change yet made in the Cash Sickness Compensation Act and, combined with the other changes voted this year by the legislature, will save the fund an estimated five and one-half per cent per year. On the basis of 1950 expenditures, this saving would have been well over $340,000, had the changes then been in effect.

It is the opinion among certain authorities in the medical profession and government and private agencies concerned with maternal and child care that a woman should not be considered physically able to work for six weeks prior to and six weeks following childbirth. In view of this opinion, the Act was amended and now provides that "An individual shall be deemed eligible for benefits for unemployment due to sickness resulting from pregnancy, if otherwise eligible, for a period not in excess of, under any circumstances, twelve consecutive calendar weeks in any benefit year, beginning with the sixth week prior to the week in which childbirth is expected and terminating not more than six weeks following such childbirth."

The amendment further specifies that "(a) if childbirth actually occurs at a date later than the expected date, no interruption shall take place in the payment of benefits; . . . (e) the limitations hereinabove set forth with regard to the number of weeks of entitlement to benefits shall not apply to unusual complications arising as a result of childbirth; (f) no individual who is receiving benefits for unemployment due to sickness resulting from pregnancy at the time of the effective date of this act shall be deprived of any rights previously established during such pregnancy; and (g) the limitations hereinabove provided shall not apply to disability resulting from miscarriage."

This legislation became effective on May 3, 1951, and all pregnancy claims filed subsequent to that date are processed in accordance with these provisions. Prior claims as stated in item "f" above were not affected.

Not all claimants, of course, will be entitled to the full twelve weeks of benefits. Some will be ineligible for the full duration because of insufficient wage credits. These credits are built up according to wages earned during a "base period" which now consists of the four last completed calendar quarters immediately preceding the date of the filing of a claim. Heretofore this "base period" was the full calendar year preceding the benefit year and allowed some claimants, out of the labor market for several months, to collect full benefits based on wages earned the previous year. Benefit credits now will be reduced by long absence from employment as the new base period so closely precedes the time when benefits are payable.

The Cash Sickness Division has simplified its procedure for the filing of claims for benefits by pregnant women and no longer requires any medical information in such cases other than the date on which childbirth is expected. This must be furnished by the attending physician over his signature.

As the pregnant woman is in regular contact with her physician during pregnancy, a simplified form for this certification is furnished to these claimants and they are requested to bring it to the doctor on a regular visit. The Form CS-1A is to be returned to the Division by the claimant eight weeks before the expected date of childbirth. This allows the agency sufficient time to obtain wage information and establish benefit rate and credits for each claim before the sixth prior week when benefits become payable.

The Cash Sickness law, as it is now amended, specifies that benefits shall be payable for definite periods before and after the actual date of childbirth. Item "a" above provides for cases where childbirth occurs at a date later than expected. But because it is not probable that the exact date can be predetermined, an adjustment will be made in cases where the actual date is before the expected date.

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# BOOK REVIEWS

*WHEN MINDS GO WRONG* by John Maurice Grimes, M. D. Publisher — J. M. Grimes, M.D. $5.00

This 237 page book, written and published by John Grimes, M.D., in 1949, was intended, obviously, to arouse the lay public about the poor conditions in state hospitals throughout the country. During his four year tenure as staff member of The Council of Medical Education and Hospitals, the author claims to have visited forty percent of the mental hospitals in the U. S. A.

These, he found to be, for the most part, politically controlled institutions where the patient not only received inadequate medical care but was also subjected to physical abuse, largely by attendants. These individuals, too often of limited intelligence and training, he says, are employed because of their political leanings and not job qualifications and "They have no place in the state hospital." They should be replaced by group leaders who are sociologically and psychologically oriented. The hospital should be relieved of all political interference, its policies being formulated by a non paid board of directors, consisting of psychologists, sociologists and economists. Their aim should be better treatment of the individual patient, rather than improvement of physical facilities. The future state hospital, Dr. Grimes declares, should be set up like a village, where patients have complete freedom.

Most of us, I am sure, will agree that there is room for improvement in state hospital systems, that political interference, where it exists, should be stamped out, and that care of the individual patient can be improved. However, the author makes so many sweeping statements and generalizations that the value of his recommendations and the purpose of the book in general is undermined. For example, his suggestion that patients be treated in a village set-up and be given complete freedom, on the surface sounds excellent, but what about the suicidal and homicidal patient, the acutely excited or deteriorated patient? It is obviously impossible to give these patients complete freedom. In fact, in most modern state hospitals the convalescent patients are given freedom in the form of ground privileges and are encouraged to visit their family, depending on individual cases. Dr. Grimes suggests that superintendents are reluctant to release patients because they are needed as workers. The doubt that Dr. Grimes really knows his subject is further increased with such statements as "All one needs to treat the functional illnesses (schizophrenia and manic depressive psychosis) is a little practical psychology." He belittles the medical profession generally and the psychiatrist in particular, accusing the latter of withholding information about patients so that he can keep on running his "highly remunerative monopoly." These statements, if for the medical profession only, would not have as serious an import as they would if they were to find their way into the hands of the laymen, particularly relatives of patients. The book would add to their bewilderment and further increase their anxiety. I am sure that the public should be aroused to take a greater interest in its state hospital system, but I feel that this book fails to accomplish this purpose.

DAVID J. FISH, M.D.

*NATURAL CHILDBIRTH* by Frederick W. Goodrich, Jr., M.D. Prentice-Hall, Inc., N. Y., 1950. $2.95

This volume was meant to be more than just a manual dealing with the concepts of the current fad, "Natural Childbirth." Its author has, as his main mission, a sincere and well-founded desire to explain to the laity the fundamental phenomena of pregnancy, childbirth and the puerperium and their physical and emotional aspects. In this reviewer's opinion he accomplishes his mission successfully with convincing sincerity and clarity. This book,

then, is a valuable addition to the several good manuals on pregnancy for the laity, already published by other authors.

The volume is well-organized and is partitioned cleverly into several sections.

The introductory chapter serves as propaganda toward spreading the realization that most (80-90%) pregnant women accomplish their state of motherhood with no significant difficulty. Goodrich's description of the uninformed and unsupported mother-to-be, cared for by the skillful yet busy physician, seemed over-exaggerated to effect a more striking contrast for the serene experience of the enlightened and properly prepared gravid patient of the thoughtful, psychosomatically-minded obstetrician.

Three chapters are devoted to each of the three trimesters and deal clearly with the special and common conditions associated with each.

Interspersed are chapters dealing with relaxation, preparatory exercises and diet. All have much to recommend their reading, although there will be many who feel that the exercises tend to be superfluous and impractical. Our author, however, has sincerely tried to point out how to incorporate the exercises into the daily routine so that they may not be additionally burdensome to the busy mother. The chapter on diet seems very practical and valuable from the patient instruction viewpoint.

His simplified explanation of the physiology and anatomy of human reproduction provides a basic and adequate education on this subject. Our author has included sections which deal in a practical manner with the problems of infant feeding and the physiology and psychology of labor. In these latter sections he attempts to show how the preparatory exercises and fundamental precepts set forth in previous chapters find their application in the actual process of childbirth.

A discussion of the Rooming in technique is described since it is usually a part of the "Natural Childbirth" technique.

Dr. Goodrich ends his manual with instructions and simplified data for the post-partum hospital period and the early going-home period. Both are directly and clearly presented and in so conservative a vein as not to provoke any obstetrician.

The book will please many young mothers-to-be because of its sympathetic and clear reassurances. It will encounter many obstetricians who will object to the faddism of the specific doctrine implied by the title of the book — "Natural Childbirth." Obstetricians, too, will object to the publisher's note on the back flap that Dr. Goodrich's book "will help mothers to go successfully, triumphantly through birth without fear, without pain." Not even Dr. Goodrich would agree that he could make Childbirth painless.

Actually the concepts of natural childbirth are not new although their propagation for public consumption is. The experienced and successful obstetrician has always practiced his own brand of psychiatry in the preparation and support of his patient for and during labor.

This manual, however, succeeds in its sincere attempt to provide reassurance and rational basic education for the expectant mother.

BERTRAM BUXTON, JR., M.D.

*BELLINI, A.* — Gerolamo Cardano e il suo tempo (Sec. XVI) — U. Hoepli — Milano — 1947.

Angelo Bellini (1872-1949), an eminent litterateur and medical historian besides a well-known dermatosyphilologist in Milan and co-editor of the 84 years old Giornale Italiano di Dermatologia e Sifilografia, writes an interesting 327 page book on Hieronymus Cardanus (1501-1576), XVI century mathematician, inventor, physician, philosopher, orator, professor of medicine in Pavia, Padua, Bologna; traveler through France, England, Germany at the invitation of scientists, cardinals, kings and emperors, to teach and to "cure" illnesses declared incurable by the best local medical minds.

The "cures" of outstanding personalities of the time by ingestion of powdered horn, powdered bones and especially powdered precious stones, as demonstrated by his universal reputation and consequent honor and wealth, makes one ponder about what the intelligentia will say of penicillin and cortisone 500 years from now.

People of the XVI centuries wore more clothes than today, at least at the beach, if there were such things as public beaches in A.D. 1500. Certainly they were not concerned about psoriasis for the above reason, but they were suffering from asthma, gout, bloody lungs, purulent bronchitis, intestinal fevers, convulsions, and historical personages were "cured" by Hieronymus Cardanus with the above mentioned prescriptions.

Hieronymus Cardanus printed 120 books and left a score of unpublished works, all written in

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Latin, as in Latin were his lessons and speeches, the only language permitted to the learned man, in contrast with what was used by the profanus vulgus. The Divine Comedy risked badly to end in the waste paper basket because it was written in Italian.

Among the inventions he will be remembered because of the cardanic or Cardan's suspension, a form of suspension in which the instrument is hung on gimbels so as to oscillate freely in all directions.

Hieronymus Cardanus "Opera Omnia" represented by 10 "in folio" volumes is sleeping comfortably on library shelves, with exception of his autobiography, contemporary of the one of Cellini. They offer different views of the times and together they are invaluable to understand the Italian "rinascimento."

A book readable like fiction, but depicting the grim reality of human suffering and despair through wars, famines, pestilences and efforts by the eminent minds of the time to solve the insolvable.

F. RONCHESE, M.D.

*A TEXTBOOK OF X-RAY DIAGNOSIS by BRITISH AUTHORS.* Edited by S. Cochrane Shanks, M.D., F.R.C.P., F.F.R., and Peter Kerley, M.D., F.R.C.P., F.F.R., D.M.R.E., Vol. II — Chest. W. B. SAUNDERS CO., Phil., 1951. $15.00

This book is part of a four volume series on x-ray diagnosis. The first edition was published in 38/9 and had five reprintings.

With the second edition the editors have increased the number of volumes from three to four. These are subdivided into Head and Neck, Chest, Abdomen, and Bones; so that they would appeal to clinicians in special branches of medicine as well as to radiologists.

As stated in the preface the object of the editors is to provide a comprehensive survey of x-ray diagnosis. Only essential details of technique are included and x-ray physics is not dealt with.

This volume is divided into two parts — the cardio-vascular system and the respiratory system. There were 17 contributors to this book, which contains 675 pages and 605 illustrations. This, of course, makes for a lengthy book and yet the book can be easily read, since the editors have been remarkably successful in omitting all extraneous matter and adhering to the essential points for making an x-ray diagnosis.

The work of authors on both sides of the water, right up to the present, is included.

One might wish for more on angiocardiography. The authors discuss the technique but do not discuss the results nor give any illustrations. However, they appear to feel that insufficient work has been completed in this phase of x-ray.

Of particular interest to the modern radiologist are the introductory chapters on the lung. These describe the normal hilus and pulmonary shadows; the lobes and interlobar fissures; the anatomy of the bronchi and broncho-pulmonary segments and the lymphatic system of the thorax.

The book appears to include every known disease of the chest; presented in a clear, concise style; thorough and yet not verbose. The illustrations are adequate.

This book is not only of great value as a textbook but also as a reference book. It appears to meet the aim of the editors.

PAUL J. VOTTA, M.D.

**The Editor acknowledges the receipt of the following books: THE MICROKARYOCYTES, THE FOURTH CORPUSCLES AND THEIR FUNCTIONS by K. G. Khorozian. Meador Publishing Company, Bost., 1951. $12.00. BEGIN NOW — TO ENJOY TOMORROW by Ray Giles. Mutual Benefit Life Insurance Company, Newark, 1951.**

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Other legislative changes affecting Cash Sickness Compensation, which after January 1, 1952, is to be officially designated as Temporary Disability Insurance, include required minimum earnings of $300 instead of $100. This provision, effective July 1, 1951, establishes $104 as the minimum amount of total credits available. It will not affect any individual who has established a benefit year prior to that date. The balance of the 1951 amendments to this law were purely administrative in nature and make it conform to certain new provisions of the Employment Security Act.